DOCUMENT RESUME

ED 077 314	HE 004 009

AUTHOR Wadsworth, W. J.; Michael, Max, Jr.
TITLE Develop a Program of Graduate and Continuing Medical Education by Selecting and Training a Faculty of Practicing Physicians. Final Report.
INSTITUTION Jacksonville Hospitals Educational Program, Inc., Fla.
SPONS AGENCY National Institutes of Health (DHEW), Bethesda, Md. Bureau of Health Manpower Education.
PUB DATE Apr 72
NOTE 190p.

EDRS PRICE MF-$0.65 HC-$6.58
DESCRIPTORS *Graduate Study; *Higher Education; Hospital Personnel; Medical Consultants; *Medical Education; *Peer Teaching; *Physicians
IDENTIFIERS *Jacksonville Hospitals Education Program

ABSTRACT

The development of a faculty of practicing physicians for use as peer teachers was investigated by the Jacksonville Hospitals Education Program (JHEP) in this 3-year study. The participants initially consisted of approximately 30 physicians selected on the basis of contribution to graduate education and apparent interest in medical education. Participation develcped tc expand the faculty to 15 practicing physicians. The faculty participated in most continuing education activities in Jacksonville. Their contributions ranged between moderating a panel of outside experts to developing and teaching solely at a conference, to actively teaching house staff and medical students. Opinion surveys, statistical analyses and other studies indicated a significant and favorable impact on medical education and the community. Appendices include related program material. (MJM)

ED 077314

CONTRACT - 71-4025

BUREAU OF HEALTH MANPOWER

Develop a Program of Graduate and Continuing Medical
Education by Selecting and Training a Faculty
of Practicing Physicians.

FINAL REPORT

A DESCRIPTION AND APPRAISAL OF THE IMPLEMENTATION OF THE THESIS IS THAT IN ONE MEDICAL COMMUNITY THERE IS A CORE OF HIGHLY QUALIFIED PEER TEACHERS WHO MAY BE DEVELOPED INTO AN ORGANIZED FACULTY FOR USE IN CONTINUING AND GRADUATE MEDICAL EDUCATION

Final Report Prepared
by
W. J. Wadsworth, Assistant Project Director
and
Max Michael, Jr., M. D., Project Director

Statistical Evaluation and Assistance
by
George Warheit, Ph. D.

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
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Submitted to
Division of Physician Manpower
Bureau of Health Manpower Education
National Institutes of Health

Submitted by
Jacksonville Hospitals Educational Program, Incorporated
655 West 8th Street
Jacksonville, Florida

April, 1972

HE 004 009

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ILLUSTRATION

Jacksonville Hospitals Map

ABSTRACT

CONTRACT - 71-4025

DEVELOPMENT OF A FACULTY OF PRACTICING PHYSICIANS FOR USE AS PEER TEACHERS

In this three year study the contractor sought to demonstrate that in some medical community there is a core of highly qualified physicians who may serve as a peer teacher. The basic premise of the operation was that "a prophet is not without honor, except in his own country".

In establishing and utilizing the faculty, the following were to be accomplished:

1. Increasing the specialty knowledge of faculty members.
2. Acquainting the faculty with medical school teaching activities.
3. Designating the faculty with certain medical school staff responsibilities.
4. Divising and conducting a continuing education program for graduates and practicing physicians in the community.
5. Using this faculty.
6. Determining the effectiveness of this program as a means of continuing education for practicing physicians and the Jacksonville faculty.
7. Evaluating the faculty, and its effect on the practicing physician.
8. Identifying new techniques of continuing education to be explored in greater detail.
9. Implementing and evaluating these new techniques identified.
10. Developing a model for potential use in other similar communities.

To carry out this program, the initial faculty consisting of approximately 30 physicians was selected by the educational leadership in the community on the basis of contribution to graduate education and apparent interest in medical education in general. From this core of 30 physicians the nucleus developed to expand the faculty to 150 practicing physicians and lay the foundation for the development of a full-time faculty at some of the local hospitals. The faculty participated in most continuing education activities in Jacksonville. Their contribution ranged between moderating a panel of outside experts to developing and teaching solely at a conference, to actively teaching housestaff and medical students.

The core of 30 practicing physicians had a substantial input and influence in the establishment of a full-time faculty in Jacksonville. Thus, the complexion of the development of the contract changed when the community of practicing physicians were induced to recruit and accept full-time faculty. The change was for the better however, so the combination of the full-time and the volunteer faculty in conjunction with a strengthened

organization unit, also a by-product of the development of the contract, yielded a "mini medical school" in Jacksonville.

Several studies were done to assess and analyze the effectiveness of this faculty and organization on continuing and graduate medical education in Jacksonville. It became apparent through opinion surveys, statistical analyses and other studies, that a sizeable percentage of all practicing physicians in JHEP and in Jacksonville felt that JHEP and the faculty have provided a significant and favorable impact on medical education in the community.

After the survey of the effectiveness of the organization and the faculty, a study of the educational differences between faculty and non faculty was conducted. This was an attempt to evaluate the faculty selection method. Since at the beginning of the contract the core faculty were actually chosen by the educational leadership of the community, it was considered mandatory that this selection process be evaluated. The results indicate that the correct selections were made and that there are several distinguishable differences between the average practicing physician and his peer who is qualified and motivated to teach. What is as significant, however, is that the leadership was able to choose an effective faculty independant of objective studies; i. e., "as a man acts, so he is."

A chain reaction of significant events in the improvement of medical and health professional education resulted directly from the exercise of this contract. Midway through the contract this organization was accepted as a division of the J. Hillis Miller Health Center of the University of Florida by the Florida State Board of Regents. As a consequence of that, the contractor began significant expansion into areas of health related education: Dentistry, Nursing, and Allied Health Professions. As a further result of these developments, the contractor firmly established a defacto "Area Health Education Center" before the term and concept became in vogue. Currently, work is under way, at the contractor's expense, to construct a computerized management information system to model and simulate the optimum development of an area health education center. Such parameters as the optimum allocation of financial and plant resources, optimum number of faculty vis-a-vis residents, medical students, nursing students, etc., and optimum organization size and output will be predicted and studied.

BACKGROUND

DESCRIPTION OF JACKSONVILLE AND NORTHEAST FLORIDA

Jacksonville is situated in the Northeast part of Florida. The city has a population of approximately 500,000 people whose primary employment modes are insurance and finance, military, services, and medium industrial concerns such as shipping, drydocking, paper manufacturing, etc.

The city sits astride the St. John's River which divides the city both geographically and by population density. Transportation across this median body is facilitated by five bridges and an expressway system. Out of the 500,000 population, approximately 20% or 100,000 are medically indigent or semi-indigent. Though there is high employment (the maximum unemployment during the past few years has been 2.8%), the wage scale is sufficiently low to qualify many in the community as poor or near poor. Approximately 20% of the population is Black.

For the most part, the eight medical hospitals and one osteopathic institution serving the community are geographically spread. (See illustration) However, there is one section of Jacksonville in which a high density of patient care and health related facilities exist. This area is denoted by the circle on the map. In this area, there are three general medical hospitals, a state division of health, the city division of health and environmental services, numerous doctors offices and the Jacksonville Hospitals Educational Program. One of the institutions in this area is the University Hospital of Jacksonville, the local public supported institution, which provides the great majority of indigent care and teaching resources for medical education.

The following illustrates additional sociomedical statistics of Jacksonville.

EMERGENCY ROOMS TRAFFIC

The following is the total amount of emergency visits in emergency rooms in all hospitals in our planning region for a one year period:

Baptist Memorial Hospital, Jacksonville September '70 - October '71	13,122
The Beaches Hospital January '71 - December '71	6,110
Bradford County Hospital January '71 - December '71	5,727
Clay Memorial Hospital January '71 - December '71	960
Edwin Fraser Memorial Hospital November '70 - October '71	2,188
Flagler Hospital January '71 - December '71	8,352
Humphries Memorial Hospital January '71 - December '71	2,355
Memorial Hospital of Jacksonville March '71 - February '72	26,794
Methodist Hospital January '71 - December '71	4,117
Riverside Hospital (Clinic) October '70 - September '71	5,003
St. Luke's Hospital October '70 - September '71	25,078
St. Vincent's Hospital January '71 - December '71	26,337
University Hospital of Jacksonville September '70 - October '71	82,835
Total......	208,978

HEALTH PLANNING COUNCIL
of the Jacksonville Area, Inc.
P. O. Box 629
Jacksonville, Florida 32

of the Jacksonville Area, Inc.

PATIENT STATISTICS REPORT FOR THE MONTH OF May, 1972

MEDICAL AND SURGICAL

Hospital	No. Beds	No. Patient Days	No. Discharges	Average Occupancy based on Discharge Days	Average Occupancy based on Patient Days (Census Days)		Average Days Stayed (Discharge Days)
Baptist	278	7,071	895	82.0	6,544	75.9	7.9
Beaches	53	1,119	139	68.1	-	-	8.1
Hope Haven	-	-	-	-	-	-	-
Jax. General	93	1,917	167	66.5	-	-	11.5
Memorial	261	7,601	1,056	93.9	-	-	7.2
Methodist	164	3,408	380	67.0	2,989	58.8	9.0
Riverside	156	3,524	472	72.9	-	-	7.5
St. Luke's	250	6,644	806	85.7	6,654	85.9	8.2
St. Vincent's	287	8,642	1,125	97.1	8,583	96.5	7.7
University	179	4,546	498	81.9	-	-	9.1
Sub-Total	1,721	44,472	5,538	83.4	24,770	81.6	8.0
Bradford	45	862	111	61.8	-	-	7.8
Clay Memorial	49	971	113	63.9	-	-	8.6
Flagler	96	1,991	308	69.9	-	-	6.5
Humphrey's	43	862	129	64.7	-	-	6.7
Total	1,954	49,158	6,199	81.2	24,770	81.6	7.9

OBSTETRICS

Hospital	No. Beds	No. Patient Days	No. Discharges	Average Occupancy based on Discharge Days	Average Occupancy based on Patient Days (Census Days)		Average Days Stayed (Discharge Days)
Baptist	31	522	158	54.3	510	53.1	3.3
Beaches	6	38	12	20.4	-	-	3.2
Hope Haven	-	-	-	-	-	-	-
Jax. General	6	11	4	5.9	-	-	2.8
Memorial	16	510	144	102.8	-	-	3.5
Methodist	-	-	-	-	-	-	-
Riverside	4	102	30	82.3	-	-	3.4
St. Luke's	23	224	66	31.4	196	27.5	3.4
St. Vincent's	28	569	191	65.6	584	67.3	3.0
University	38	652	208	55.3	-	-	3.1
Sub-Total	152	2,628	813	55.8	1,290	50.7	3.2
Bradford	9	48	15	17.2	-	-	3.2
Clay Memorial	5	48	13	31.0	-	-	3.7
Flagler	14	158	47	36.4	-	-	3.4
Humphrey's	4	36	12	29.0	-	-	3.0
Total	184	2,918	900	51.2	1,290	50.7	3.2

[illegible]

Hospital	No. Beds	No. Patient Days	No. Discharges	Average Occupancy based on Discharge Days	Average Occupancy based on Patient Days (Census Days)		Average Days Stayed (Discharge Days)
Baptist	70	1,247	267	57.5	1,340	61.8	4.7
Beaches	2	129	41	208.1	-	-	3.1
Hope Haven	72	1,009	188	45.2	-	-	5.4
Jax. General	8	79	9	31.9	-	-	8.8
Memorial	-	-	-	-	-	-	-
Methodist	-	-	-	-	-	-	-
Riverside	-	-	-	-	-	-	-
St. Luke's	32	525	91	52.9	662	66.7	5.8
St. Vincent's	34	867	214	82.3	818	77.6	4.1
University	40	999	124	80.6	-	-	8.1
Sub-Total	258	4,855	934	60.7	2,820	66.9	5.2
Bradford	-	-	-	-	-	-	-
Clay Memorial	6	55	12	29.6	-	-	4.6
Flagler	21	167	52	25.7	-	-	3.2
Humphrey's	4	66	24	53.2	-	-	2.8
Total	289	5,143	1,022	57.4	2,820	66.9	5.0

PSYCHIATRIC

Hospital	No. Beds	No. Patient Days	No. Discharges	Average Occupancy based on Discharge Days	Average Occupancy based on Patient Days (Census Days)		Average Days Stayed (Discharge Days)
Baptist	36	826	52	74.0	971	87.0	15.9
Beaches	5	4	2	2.6	-	-	2.0
Hope Haven	-	-	-	-	-	-	-
Jax. General	-	-	-	-	-	-	-
Memorial	26	561	50	69.6	-	-	11.2
Methodist	-	-	-	-	-	-	-
Riverside	-	-	-	-	-	-	-
St. Luke's	20	372	27	60.0	553	89.2	13.8
St. Vincent's	36	574	51	51.4	698	62.5	11.3
University	44	2,109	139	154.6	-	-	15.2
Sub-Total	167	4,446	321	85.9	2,222	77.9	13.9
Bradford	-	-	-	-	-	-	-
Clay Memorial	-	-	-	-	-	-	-
Flagler	-	-	-	-	-	-	-
Humphrey's	-	-	-	-	-	-	-
Total	167	4,446	321	85.9	2,222	77.9	13.9

SUMMARY

Hospital	No. Beds	No. Patient Days	No. Discharges	Average Occupancy based on Discharge Days	Average Occupancy based on Patient Days (Census Days)		Average Days Stayed (Discharge Days)
Grand Total	2,594	61,665	8,442	74.7	21,192	[illegible]	[illegible]

[illegible]

PATIENT STATISTICS REPORT FOR THE FISCAL YEAR 1971
(365 days - October 1, 1969 through September 30, 1971)

MEDICAL AND SURGICAL

Hospital	No. Beds*	No. Patient Days	No. Discharges	Avg. Occupancy based on Discharge Days	Avg. Occupancy based on Census Days		Avg. Days Stayed (Discharge Days)
Baptist	278	80,250	10,856	79.0	77,945	76.8	7.4
Beaches	53	14,297	1,878	74.0	-	-	7.6
Hope Haven	-	-	-	-	-	-	-
Jax. General	-	-	-	-	-	-	-
Memorial	229	66,927	8,845	80.0	-	-	7.6
Methodist	164	37,194	4,379	62.1	37,394	62.5	8.5
Riverside	155	45,053	5,337	79.6	-	-	8.4
St. Luke's	269	79,424	9,164	80.9	81,320	82.8	8.7
St. Vincent's	287	92,380	11,955	88.1	93,555	89.3	7.7
University	156	49,813	5,323	87.5	-	-	9.4
Sub-Total	1,591	465,338	57,737	80.1	290,214	79.7	8.1
Bradford	45	11,622	1,500	70.8	-	-	7.7
Clay Memorial	49	15,998	1,905	89.4	-	-	8.4
Flagler	96	26,071	3,560	74.4	-	-	7.3
Humphrey's	42	7,961	1,394	51.9	-	-	5.7
Total	1,823	526,990	66,096	79.2	290,214	79.7	8.0

OBSTETRICS

Hospital	No. Beds*	No. Patient Days	No. Discharges	Avg. Occupancy based on Discharge Days	Avg. Occupancy based on Census Days		Avg. Days Stayed (Discharge Days)
Baptist	31	7,199	2,215	63.6	7,104	62.8	3.3
Beaches	8	584	159	20.0	-	-	2.9
Hope Haven	-	-	-	-	-	-	-
Jax. General	-	-	-	-	-	-	-
Memorial	16	5,990	1,718	102.6	-	-	3.5
Methodist	-	-	-	-	-	-	-
Riverside	4	1,448	414	99.1	-	-	3.5
St. Luke's	23	4,227	1,226	50.1	3,584	42.7	3.4
St. Vincent's	28	8,632	2,679	84.4	7,785	76.2	3.2
University	29	10,410	3,523	98.4	-	-	3.0
Sub-Total	139	38,490	11,934	75.9	18,473	61.7	3.2
Bradford	9	524	171	16.0	-	-	3.0
Clay Memorial	5	557	200	30.5	-	-	2.8
Flagler	14	1,643	562	32.1	-	-	2.9
Humphrey's	4	491	162	33.6	-	-	3.0
Total	171	41,705	13,029	66.8	18,473	61.7	3.2

*Average number of beds during the fiscal year.

**September and October, 61 days.
Footnotes apply to all pages of Report.

PATIENT STATISTICS REPORT FOR THE FISCAL YEAR 1971

PEDIATRICS

Hospital	No. Beds*	No. Patient Days	No. Discharges	Avg. Occupancy based on Discharge Days	Avg. Occupancy based on Census Days		Avg. Days Stayed (Discharge Days)
Baptist	70	13,229	2,997	51.8	16,955	66.4	4.4
Beaches	2	1,849	478	253.3	-	-	3.9
Hope Haven	72	13,443	2,292	51.1	-	-	5.9
Jax. General	-	-	-	-	-	-	-
Memorial	-	-	-	-	-	-	-
Methodist	-	-	-	-	-	-	-
Riverside	-	-	-	-	-	-	-
St. Luke's	31	8,182	1,267	72.3	8,143	72.0	6.5
St. Vincent's	34	10,429	2,661	84.0	9,518	76.7	3.9
University	28	10,089	1,241	98.7	-	-	8.1
Sub-Total	237	57,221	10,936	66.1	34,616	70.3	5.2
Bradford	-	-	-	-	-	-	-
Clay Memorial	6	1,338	284	61.0	-	-	4.7
Flagler	21	2,901	767	37.8	-	-	3.8
Humphrey's	4	437	167	33.4	-	-	2.9
Total	268	61,947	12,154	63.3	34,616	70.3	5.0

PSYCHIATRIC

Hospital	No. Beds*	No. Patient Days	No. Discharges	Avg. Occupancy based on Discharge Days	Avg. Occupancy based on Census Days		Avg. Days Stayed (Discharge Days)
Baptist	33	11,508	668	95.5	10,670	88.6	17.2
Beaches	5	930	165	51.0	-	-	5.6
Hope Haven	-	-	-	-	-	-	-
Jax. General	-	-	-	-	-	-	-
Memorial	26	5,532	584	58.3	-	-	9.5
Methodist	-	-	-	-	-	-	-
Riverside	-	-	-	-	-	-	-
St. Luke's	15**	737	57	80.5	-	-	12.9
St. Vincent's	21	7,590	607	99.0	7,557	98.6	12.5
University	44	25,788	1,838	160.6	-	-	14.0
Sub-Total	144	52,085	3,919	108.5	18,227	92.3	13.3
Bradford	-	-	-	-	-	-	-
Clay Memorial	-	-	-	-	-	-	-
Flagler	-	-	-	-	-	-	-
Humphrey's	-	-	-	-	-	-	-
Total	144	52,085	3,919	108.5	18,227	92.3	13.3

SUMMARY

Hospital	No. Beds	No. Patient Days	No. Discharges	Avg. Occupancy based on Disc. Days	Avg. Occup. based on Census Days	Avg. Days Stayed(Disc.)

HEALTH PLANNING COUNCIL
of the Jacksonville Area, Inc.

COMPARATIVE PATIENT STATISTICS REPORTS
Fiscal Years 1968, 1969, 1970, 1971

	Medical & Surgical				Obstetrics				Pediatrics				Psychiatry				TOTALS			
	1967-1968	1968-1969	1969-1970	1970-1971	1967-1968	1968-1969	1969-1970	1970-1971	1967-1968	1968-1969	1969-1970	1970-1971	1967-1968	1968-1969	1969-1970	1970-1971	1967-1968	1968-1969	1969-1970	1970-1971
ds	1,361	1,604	1,714	1,823	161	176	174	171	263	263	263	268	91	94	119	144	1,873	2,137	2,270	2,406
Change		+243	+110	+109		+15	-2	-3		-	-	+5		+3	+25	+25		+264	+133	+136
Percent		+17.9	+6.9	+6.4		+9.3	-1.1	-1.7				+1.9		+3.3	+26.6	+21.0		+14.1	+6.2	+6.0
tient ays	432,374	468,744	515,343	526,990	35,916	39,306	41,957	41,705	61,666	61,512	63,746	61,947	34,241	37,782	40,447	52,085	564,197	607,344	661,523	682,727
Change		+36,370	+46,599	+11,647		+3,390	+2,651	-252		-154	+2,234	-1,799		+3,531	+2,665	+11,638		+43,147	+54,179	+21,234
Percent		+8.4	+9.9	+2.3		+9.4	+6.7	-.2		-.2	+3.6	-2.8		+10.3	+7.1	+28.8		+7.6	+8.9	+3.2
is-harges	51,355	55,182	62,240	66,096	11,181	11,713	12,584	13,029	10,827	11,241	11,920	12,154	2,131	2,403	2,799	3,919	75,494	80,539	89,543	95,918
Change		+3,827	+7,058	+3,856		+532	+871	+445		+414	+679	+234		+272	+396	+1,120		+5,045	+9,004	+5,65
Percent		+7.5	+12.8	+6.2		+4.8	+7.4	+3.5		+3.8	+6.0	+2.0		+12.8	+16.5	+40.0		+6.7	+11.8	+6.3
verage Occupancy	86.8	83.8	82.4	79.2	61.0	64.7	66.1	66.8	64.1	64.1	66.4	63.3	102.8	113.8	113.9	108.5	82.3	77.9	80.6	78.1
Change		-3	-1.4	-3.2		+3.7	+1.4	+.7		-	+2.3	-3.1		+11	+.1	-5.4		-4.4	+2.7	-2.5
Percent		-3.5	-1.7	-3.9		+6.1	+2.2	+1.0			+3.6	-4.7		+10.7	+0.1	-4.7		-5.3	+3.5	-3.1
verage Days Stay	8.4	8.5	8.3	8.0	3.2	3.4	3.3	3.2	5.7	5.5	5.3	5.0	16.1	15.7	14.5	13.3	7.5	7.5	7.4	7.3

The above chart represents a comparative breakdown, by major categories, of the patient statistics reports for the fiscal years October 1 through September 30, 1968, 1969, 1970, and 1971. Entries in lines labelled "Change" are given in exact figures. The percentages on the next line are computed using the preceding year's entry as the base. The decrease in occupancy rates in 1971 indicates the community is entering a state of surplus as regards acute care beds.

PLANNED HOSPITAL CONSTRUCTION

Duval County, Florida

Hospital:	Existing Beds	Beds to be Added	Total	Completion Date
Baptist	415	179	594	1973
Memorial of Jacksonville	303	---	303	1971
University Hospital of Jacksonville	262	246	508	1971
Methodist	164	---	164	1967
Riverside	161	---	161	1968
St. Luke's	325	---	325	1970
St. Vincent's	370	138	508	1975
Beaches	68	---	68	1968
Hope Haven	72	---	72	1968
Jacksonville General (Doctors' Osteo)	---	104	104	1971
TOTAL	2,140	667	2,807	

HEALTH PLANNING COUNCIL
of the Jacksonville Area, Inc.
P. O. Box 629
Jacksonville, Florida 32202

DESCRIPTION AND HISTORY OF JACKSONVILLE HOSPITALS EDUCATIONAL PROGRAM AND ITS RELATIONSHIP TO THE COLLEGE OF MEDICINE, UNIVERSITY OF FLORIDA

The contractor is Jacksonville Hospitals Educational Program, JHEP. The corporation was established in 1958 to coordinate and manage the residencies of member hospitals within the city. It is believed that this was the first such organization in the United States and has been greatly emulated in other communities.

From 1958 through 1967, JHEP grow as an organization by expanding in number of residencies; increasing efforts and continuing education programs for practicing physicians; developing a central library system through which all medical library activities within the city are co-ordinated and managed; and conducting small research projects for the National Institutes of Health. Simultaneously, the College of Medicine at the University of Florida was maturing and becoming a high quality medical school and health science center.

In 1967, the leadership of both organizations sought to initiate plans through which the medical school could enhance its clinical facilities without additional capital outlay while simultaneously becoming more of a resource to the community in Northeast Florida. Also, JHEP sought to render "academic respectability" to its educational exercises. These divergent but not conflicting goals thus found expression in the Executive Director of JHEP being appointed the Assistant Dean for Jacksonville programs of the College of Medicine. In December of 1968 when this contract began, the formal organizational relationships between JHEP and the College of Medicine were not fully crystalized nor was there any great activity jointly sponsored.

During the exercise of the contract, and largely because of the exercise of it, JHEP became a full division of the J. Hillis Miller Center of the University of Florida. This action was designated by the Board of Regents in October, 1969. Through this mechanism, the Director of JHEP became the full-time, non-volunteer Assistant Dean for Jacksonville programs in the College of Medicine. Moreover, this mechanism allowed full academic appointments for qualified full-time physicians serving in JHEP hospitals. This greatly facilitated the administrative arrangements required while securing volunteer (adjunct) faculty appointments for the faculty to be developed in the contract.

To render the Jacksonville division of the J. Hillis Miller Center more productive, state appropriations began in 1970. Initially, this amount was approximately $100,000 annually and consisted principally of funds for expense items such as printing, communications, travel, etc. and consultant services to be used for visiting lecturers who participate in the continuing and graduate medical education programs in Jacksonville. During 1970 and 1971 no salary lines were appropriated directly to JHEP. However, through various trade-off mechanisms, the Assistant Dean for Jacksonville programs was allowed to become a full paid faculty member of the College of Medicine. The budget for fiscal year 1972-73 has line requests for staff and faculty positions. At the time of the writing of this report, the outcome of this request is not known. However, administrative officials at the Health Center have expressed optimism that at least partial funding of Jacksonville faculty and staff will be forthcoming. In addition to the organization suprastructure established as a result of the contract, the library system of JHEP strengthened to begin development as a biomedical communications system for the physicians of Northeast Florida (a learning resource center).

The JHEP central library began, as did JHEP, as an experiment to see if hospitals could cooperate in establishing a community library. The original objectives were sharing of resources, establishing a central repository for expensive and difficult to find journals and books, and hiring a full-time professional medical librarian to coordinate and manage the system for the entire community. This facet of the contractor's activity has been highly successful and greatly emulated in other communities throughout the country. There are approximately 7000 bound volumes and 250 subscriptions to professional periodicals. The library is noncirculating, that is to say, one does not check out a book or periodical. Rather, a request is made directly to the library by phone or through a member hospital library for a particular bibliography, literature search or article. The request is processed at the central library and fulfilled by the timely delivery of the service to the user. The services consist of xeroxed articles, reference questions, manual and computerized bibliography and literature searches. Recent statistics indicate that the contractor can virtually guarantee to a physician user that 60% of requests can be delivered to his office in less than three working days.

The brief summary of the history and activity of the contractor should serve as a background sketch, partially describing the climate extant at the onset of contract activity.

PART I

CONTRACT OBJECTIVE

The basic premises which precipatated this contract were that it is becoming increasingly difficult, if not impossible, for medical schools to supply instructors to meet the demand for continuing medical education in the community; and in this community as in others, a core of highly qualified physicians exist which can be developed into a continuing education faculty. In order to develop this faculty, however, three obstacles of most practicing physicians would have to be overcome. It is to be remembered that reception of the MD degree does not automatically constitute an individual with the ability to teach. The obstacles which had to be overcome were: (a) lack of adequate preparation by the teacher, (b) unsophisticated approach to teaching and (c) resistance of the practicing physician to learn from his peer.

With these basic tenets in mind the contract developed with the following objectives.

1. Select and train a faculty of thirty to forty practicing physicians from the Jacksonville metropolitan area at the College of Medicine University of Florida or other appropriate medical teaching facility. Training of these physicians shall be directed to:

   a. increasing knowledge of their specialty
   b. acquainting this faculty with medical school teaching activities
   c. faculty responsibilities as medical school staff appointees

2. Devise and conduct a continuing educational program for graduate and practicing physicians using the faculty in 1. above.

3. Utilize consultants in the field of education, behavioral science, sociology, and medicine to determine ways of analyzing the:

   a. effectiveness of the program as a means of continuing education in the Jacksonville "faculty"
   b. evaluation of each faculty member as a teacher and the effect of his participation in the program upon his effectiveness as a practing physician
   c. identification of new techniques of continuing education to be explored in greater detail
   d. implementation and evaluation of new techniques identified in c. above

4. Develop a format for potential use for continuing education of practicing physicians based upon this method of cooperation between a medical teaching facility and physicians of a metropolitan area.

INITIAL PLANS FOR THE ESTABLISHMENT AND DEVELOPMENT OF THE VOLUNTEER FACULTY

As indicated in the background description of JHEP, the Project Director, Max Michael, Jr., M. D., was considered in the community to be the center of graduate medical education. As such, he had access to all local physicians who had an interest in teaching housestaff. Out of a professional community of approximately 450 physicians, 10% or approximately 45, were active in teaching. This teaching activity consisted primarily of grand rounds, conferences with housestaff, and hospital staff conferences. It was natural then to consider this group as the core for development into a full continuing and graduate medical education faculty. The initial plans for this development included naming this 10% group, inviting them to several conferences to practice teaching in interdisciplinary subjects, sharpen their instructional abilities, and take a one week sabbatical at a nearby medical school to refresh their knowledge in their specialty field. The basic rationale for this approach is that the best teachers are probably those who seek out teaching as an advocation. This has been demonstrated in other professions and certainly medicine is no exception. The most qualified professional whether he be an engineer, accountant, attorney or physician is not necessarily interested in teaching. By the same token at the other end of the spectrum there may be physicians of lower technical ability which have a great driving interest in teaching but do not lack the professional skills. Of course between these two extremes, the highly respected and successful technical professional and the less respected, less affluent and less technically adept professional lies the great majority of physicians in the United States. Therein resides the potential faculty. It would be utopian to hope for a faculty consisting of high motivated, "called" teachers from the super technical professional group.

In the process of selecting a faculty however, must come certain amounts of thought into the objectives of establishing a faculty. It thus became necessary to define the objective of having a faculty, i.e., what will be the behavior of the "faculty member"? What will he do that will distinguish him from other practitioners who are active in education? Though the core was to consist of approximately 45 physicians, there were an additional sixty physicians who participated in graduate medical education to a lesser degree. Their participation may have been identical in numbers of hours but of a lower quality as determined by the Project Director; the primary determinant of admission to the core faculty was not in time spent however, but in the quality of training rendered. To return to the question of defining faculty certain parameters must be examined.

1. The faculty member won't conduct formal courses or be a preceptor in the sense of a university centered teacher, however, he will lecture occasionally to housestaff and his peers.

2. He will also teach face to face with a one to one relationship occasionally.

3. He won't write books, extensive articles or spend much time in research, however, he will occasionally perform in these areas.

4. His activity in writing and research will seldom constitute a measure of his contribution and importance to the educational program.

With the above limits set on the field describing the core faculty, it then became necessary to formulate certain evaluation precepts. How should the effectiveness of the faculty member be evaluated? How can one evaluate the change (if any) in acceptance by the community?

These derive to a more basic question regarding an assessment of success. Are we trying to change the behavior of the community - acceptance of the "profit in our own country"; or are we trying to change the behavior of the teachers in the community? Are we trying to upgrade the academic quality of those acting as de facto teachers of their peers and housestaff by giving them the academic cloak and organization of a medical school environment?

It thus became apparent during the planning stages, that without a careful definition of who and what and why or organizing and cloaking a faculty, a dilemma in assessing success three years later would be brought upon us. The solution became to visualize the faculty as the linking pin between the medical school, with its up to date literature, research and practice, and the practicing medical comminity, succumbing to the pressure of high patient volume and thus unable to keep abreast.

Thus, initial planning for the development program was a five step process enumerated below.

I. ANALYZE THE PRESENT DE FACTO "FACULTY"

II. DETERMINE OBJECTIVES OF THE DEVELOPMENT PROGRAM

   A. Faculty Manpower Requirements (quantitative demensions)

      1. Replacement needs
      2. Growth needs

         a. historic growth
         b. planned expansion

III. IMPROVED PERFORMANCE NEEDS

   A. Faculty Personnel Inventory (qualitative dimensions)

      1. Inventory of current capabilities
      2. Appraisal of current performance
      3. Estimate of potential growth

B. Terminal Behavior Expected

IV. ESTABLISH OPPORTUNITIES FOR DEVELOPMENT

A. Internal Resources

1. Training programs
2. Committee assignments
3. Coaching (preceptorships)
4. Planned sequencing of increased responsibility

B. External Sources

1. University programs
2. Professional meetings away from local environment

V. RENDER THE CLOAK OF "ACADEMIA"

VI. EVALUATE THE PROGRAM

A. Continue Performance Appraisal

B. Opinion and Attitude Surveys

C. Feedback to I. and II. Above

The above consisted of the initial plans for the development. Since this plan served as general policy guidelines and not specific procedures it will not be strictly followed in this report.

IMPLEMENTATION

The formal implementation of the faculty development began with an announcement to the approximately 45 practicing "teachers" in the medical community to attend a general information conference. The intention of this meeting was to inform the individuals of the contract; briefly explain the plan for development of the contract; and inform them of their acceptance as the core faculty.

Professional Climate

As previously mentioned, the Jacksonville medical community consists of approximately 500 physicians. The sociodemographic, political, and economic factors influencing medical practice and the general populous are those of many other southern cities approaching heavy industrialization. It is thus a conservative professional community with approximately 13% of the profession being general practitioners. Other specialties break down as follows: Surgery and related specialties 30%; Internal Medicine and related specialties 25%; OB-GYN 9%; Pediatrics 7%; hospital based and other specialties 16%.

The question of developing a full-time faculty had been repeatedly brought to the academic and political leadership of the professional community but with no avail. The standard fears, uncertainties and insecurities that plagued other communities prior to the inception of full-time physicians were apparent in Jacksonville also. It therefore was apparent that to develop a faculty in Jacksonville, one must necessarily utilize practicing physicians. See Appendix 3. for a more complete discussion of the problems and solutions of establishing a full-time faculty in a nonacademic medical community.

Leadership

As with any endeavor, leadership, i. e., management,is the most important resource. Thus, since there was no objective survey available to determine who were the best teachers or who would make an acceptable core faculty, it was incumbent upon the Project Director to handpick these individuals. (Parenthetically, it is interesting to note that it is doubtful that even if an objective survey were available, that it would be capable of implementation in a community such as Jacksonville.) That is to say the contractor finds it doubtful that an outside agency could enter this community, make an objective assessment of the teaching capabilities of all physicians interested in that activity and from this information extract a core faculty. The contractor feels that it is therefore of paramount importance that in any attempt to duplicate the effort made in Jacksonville that the primary concern must be to identify an academically oriented physician in the community to act in the leadership role. Ideally, the leader should be a full-time physician at a hospital rather than at private practice. The reasons for this essentially are demonstrated administrative ability, greater concern for education than for a group of private patients and a fixed salary somewhat independent of the amount of time expended in the profession.

Program

Wroking with the core faculty, the Project Director began a series of communications meetings to ascertain what type of conferences, i.e., subject matter, place, time, etc. should be conducted for the faculty. The primary concern of most of the faculty was for lack of confidence in planning and conducting educational exercises. Thus, in July of 1969 a conference on the Educational Uses of Audiovisuals was conducted. The proceedings and discussion of this conference are in the Appendix 6.

Other concerns of the faculty were alleviated through several means. The primary method to have been used was sending the faculty member to a medical school in order to enhance his teaching competence, specialty knowledge and pedagogic expertise. This method was somewhat unsuccessful and will be dilated on more extensively in Part II. Another method used was the provision of educational conferences wherein specialists in education were available to the faculty for small group discussion and preceptorships. This was somewhat more successful than attempting to send the physician out of town, however, the contractor found that the most successful operations were large conferences conducted either during a normal hospital staff conference or on Saturdays.

Each of the foregoing methods were used with the primary objective merely of making the faculty more comfortable in an academic setting - more comfortable with pedagogic terms and techniques.

FINANCES

The financial structure of the contractor, which lent itself so successfully to adaptation of the contract to develop the faculty, revolves around hospital member support. The total budget of the contractor including its central medical library is approximately $135,000 per year. Of this, approximately 40% is provided by hospital members, 40% by the State of Florida, and 20% through Federal and miscellaneous grants. With a budget this small, it is obviously impossible to have a viable faculty in which members are paid honoraria or salaries. It was therefore fortunate that the honorarium programmed for faculty development was unnecessary. In addition, as the volunteer faculty developed and provided the initiative to establish a full-time faculty, it was possible to secure direct hospital support to defray these costs.

The contract costs amounted to approximately $75,000 over a three and one half year period. These funds were utilized to meet the obligations of employing educational consultants, conducting conferences, reimbursing for staff time, and travel of faculty and staff.

UNIVERSITY OF FLORIDA "CARROT" - THE ACADEMIC CLOAK

As commented above, it was found unnecessary to pay the core faculty an honorarium for their time. The contention of the members was that the amount of time expended away from their private practice was not nearly compensated for by the honorarium. Thus, the faculty preferred to donate the entire time rather than receive compensation for a portion.

If honorarium, or money, was not a motivating factor, what then was? The carrot, the impetus provided to the faculty to generate interest, enthusiasm and the donation of time was the academic appointment through the College of Medicine University of Florida. It was found that the aura of being knighted "teacher" with a voluntary appointment at the medical school was sufficient to motivate the greatest majority of the faculty. Interestingly enough, some physicians went out of their way to accomplish the administrative details required of the faculty appointment and then promptly diminished their interest and contribution to the teaching program. On the other hand, there were others who consistently failed to comply with the simple administrative tasks for securing a faculty appointment but continued and improved their commitment of time and energy to the teaching program. On the whole however, the contractor found that the greatest single motivating force to establishing the faculty was the academic appointment.

IMPLEMENTATION

The contract called for a core faculty consisting of approximately 40 individuals to be established. In the conduct of the contract, JHEP went further than that by developing the core faculty into a group of approximately 125 practicing physicians, and approximately 20 full-time physicians at local hospitals. Whereas physicians in the community (and the de facto faculty, which existed prior to initiation of the contract) had thwarted efforts to develop a full-time faculty, after implementation of the contract and expension of the faculty, this group of individuals provided the primary initiative to recruit, maintain and develop a staff of full-time clinicians with full academic appointments at the College of Medicine University of Florida. Thus, a full-time faculty was established after the volunteer faculty had become more exposed to academia.

The faculty has now been established totaling approximately 145 individuals. Of this 145, approximately 20 are full-time clinicians with full academic appointments at the School - (College) of Medicine. The other 125 are practicing physicians with levels of voluntary appointments ranging from Clinical Instructor to Clinical Professor. The distribution of levels of appointments for the volunteer faculty are as follows:

Clinical Instructor	22
Clinical Assistant Professor	66
Clinical Associate Professor	39
Clinical Professor	7

In advertising the establishment of and utilization of the faculty to the community and to prospective housestaff and medical students, the entire JHEP faculty was listed in a section of the catalogue of the College of Medicine. (See Appendix 5). This small addition to the catalogue was one more way to demonstrate that the JHEP faculty is indeed the College of Medicine faculty. This also is an act of great significance to the faculty.

RESULTS

As a result of setting up the continuing education faculty, JHEP was able to provide most of the desired continuing education of the faculty members through programs of self-teaching. Other results of establishing the faculty include improved communication between the administration of JHEP and the College of Medicine with practicing physicians; more evident interest in the education of peer physicians, housestaff and medical students; and more acceptance of the College of Medicine input and influence on the conduct of medical education in Jacksonville.

Description of the Faculty

The faculty established under this contract consists of approximately 145 individuals, with 20 of these being full-time clinicians with academic appointments. The specialty distribution of the faculty is compared below with the distribution of physicians in the community.

30% of M. D.'s in Jacksonville in practice five years or less

29% of M. D.'s in Jacksonville in practice over 15 years

* * *

75% use JHEP Library facilities at least "several times a year" - includes hospital libraries

61% of practicing M. D.'s in Jacksonville are between 35 - 54 years old

36% grew up in Florida

26% grew up in Southeast

12% are Foreign Medical Graduates (most from Cuba)

OF THOSE WHO HAD SPECIALTY TRAINING .....

24.5% received it in Jacksonville

On a scale of 1-10 (Best #10), 60% felt JHEP to be "6" or above

91% felt it would be "6" or better three years from now

To more adequately provide a quantitative description of the faculty, a statistically valid random survey was made to compare faculty with nonfaculty physicians in the area. The following results demonstrate a profile of faculty members in Jacksonville.

These and all other statistics in this report come from the same survey conducted by the Department of Medical Sociology, University of Florida, Gainesville, Florida.

1. No difference "how long in practice in Jacksonville" between faculty and non faculty.
2. Faculty use the medical library facilities significantly more than non faculty.
3. Region where MD is received is no factor in seeking a faculty position; however skill, "stay current" and "enjoy teaching" are factors.
4. Faculty tended to be younger than non faculty.
5. Faculty tended to be more active in local medical society and the community than non faculty.
6. Faculty are more likely to subscribe to more journals than non faculty.
7. Faculty significantly more likely to attend educational conferences.
8. Faculty tended to be more established in practice, though younger, than non faculty.

A more complete appraisal and evaluation on the differences between faculty and nonfaculty physicians are included under Part III, EVALUATION.

Educational Programs

The faculty worked on the following educational programs in varying degrees. In some instances, members were only moderators of program segments. In other instances, the faculty planned, executed and taught at the conference.

3/7,8,9/69	SECOND ANNUAL JHEP INSTRUCTIONAL COURSE IN SURGERY OF THE HAND
3/17/70	SELECTION AND USE OF ANTIBIOTICS
4/24/70	IMMUNOLOGY THERAPY AND CHEMOTHERAPY
9/23/70	HYPERTENSION
10/28,29,30/70	THE CARDIAC SURGICAL PATIENT AND THE NURSE
3/6/71	SECOND ANNUAL STROKE CONFERENCE
9/10,11/12/71	TIPS, TRICKS, TECHNIQUES AND TRAPS IN PEDIATRIC AND ADOLESCENT MEDICINE
9/17,18/71	CURRENT CONCEPTS OF CARDIAC CONDUCTION
10/9/71	A POSTGRADUATE SEMINAR IN IMMUNOLOGY AND INFECTIOUS DISEASE
10/15/71	DAY OF HEMATOLOGY
10/19/71	DAY OF CARDIOLOGY
11/5/71	PULPAL CONSIDERATIONS IN RESTORATIVE DENTISTRY
11/20/71	DRUG INTERACTION
11/30/71	CHANGING MEDICAL LIABILITY LAW
2/17/72	SEMINAR IN CORONARY CARE
2/7,8/72	THE ACUTE CARDIAC EMERGENCY
2/24/72	ANTIBIOTICS CONFERENCE
3/6/72	GOUT AND GOUTY ARTHRITIS
3/13/72	HUMAN SEXUALITY
3/24/72	HYPERTENSION
3/24/25,72	ORAL AND MAXILLOFACIAL SURGERY
4/11/72	TUMOR CONFERENCE
4/11/72	HYPERLIPIDEMIA

Activities of the Faculty

While the faculty were primarily concerned with educational programs, members were also active in several other aspects of medical education. This included assisting in the development of grant proposals; establishing a kidney dialysis home training and professional education center; representing the Jacksonville faculty at regional and national meetings concerned with general medical education topics; recruiting housestaff and acting as preceptors for medical students; recommending the establishment of an office of educational specialization within JHEP; and recommending and working on the establishment of a "JHEP College of Postgraduate Medicine."

These last two items have been most fruitful and have culminated in JHEP actively seeking funding to recruit an educational technology specialist. Faculty leaders who have promoted this concept visualize the educational technologist to be an individual highly skilled in educational "systems." This office within JHEP will become a great resource to the volunteer, as well as full-time faculty, in assisting in the development of educational objectives, implementing programs, and formulating modes of evaluation.

Realizing the capabilities,the faculty has as an educational entity prompted several individuals to develop the idea of a JHEP "College of Postgraduate Medicine". This "College" would essentially be an extension, and complete development of the concept of the continuing educational faculty established through this contract. Briefly, the "college" will consist of JHEP faculty members teaching long term postgraduate courses to thier peers. Using techniques found in adult education courses including sylabi, tests, and certificates, the "college" will begin a series of exercises in hematology, pharmacy, genetics, etc. The aim will be to provide detailed refresher courses to practicing physicians. A professional adult educator will be employed and the "students" will be instructed and tested in each subject before being allowed to progress from course to course.

PART II

PROBLEMS ENCOUNTERED

In establishing the continuing education faculty, several problems were encountered. The most notable of these were motivation, selection and acceptance of the faculty. In addition, after the establishment of the volunteer faculty, another problem is that of the "town gown" syndrome. This occurred when the contractor established a full-time faculty at some of the hospitals in the community.

Motivation

In any educational endeavor, whether at the level of student or teacher, motivation is the primary problem. It has often been said that indeed the teacher merely motivates the student to learn at his own speed in the things the teacher wishes to be learned.

The question of motivating the teacher, however, is somewhat different, in that administration must motivate the teacher to practice within the educational objectives and framework of the organization. What this means in the current model, is motivating the practicing physicians to donate a specified amount of time at given intervals to the teaching program. Also, the teacher is required to practice such pedagogic techniques as the administration may require, and adhere to certain general professional standards. In line with this, it was necessary, at the outset of the contract, to send faculty members out of the city to visit medical schools to brush up on their chosen specialty in order to teach. However, the problem encountered was that very few physicians were willing to sacrifice the amount of time, i.e., money, required to partake of a sabbatical of five to seven days away from their practice.

Selection

As discussed previously, the primary problem in establishing the faculty was the one of selection. Who should be on the volunteer faculty? What should be their rank and status vis-a-vis the University of Florida, College of Medicine? What should their relationship be to the organizational structure already established within JHEP to conduct medical education. Almost any criteria on which to base selection will generate discrepancies and inconsistencies. For example, it was found that particular individuals who were very qualified practitioners and highly respected by their peers were not interested in either teaching or participating in a volunteer faculty. Also, the opposite was encountered. There were individuals who were not considered to be the superior medical practitioner or teacher nor considered to be the superior medical practitioner or teacher nor considered to rank high in the estimation of his peers who desired association with the volunteer faculty and an academic appointment.

Thus, the problem of selection plagued the early work on the contract and continues to be a sore spot in current activities. There appears to be no fullproof certain mode for testing and ability recognized by peers apparently are viable perimeters of selection. However, nearly all academic administrations must encounter the same problem. The central problem is to identify who is going to be a good teacher and who is not.

The faculty were thus, subjectively chosen from the group of practicing physicians in the community. Each chosen was mailed various correspondence describing the selection process to the prospective faculty member in that he was being considered by the administration at the College of Medicine for acceptance to the volunteer faculty.

Acceptance

Usually, when any agency suddenly knights 20% of a population with some honor deemed important by the entire group, the remaining 80% can be expected to be somewhat dissatisfied. The contractor found this to be the case in very few instances. Quite the contrary, whenever the academic clock, by way of the appointment through the College of Medicine, was issued to the faculty members, acceptance by the medical community was no problem at all.

Another facet of acceptance however, was the problem of the "town gown" syndrome which so typified community relationships in an area where there is an academic center. This problem manifests itself by several modes which are discussed in detail in Appendix 3. The sensation of the volunteer faculty being "squeezed out" of the educational programs appeared as a problem early in the development of the faculty and continues to be an area of concern and work. Though the faculty have been receptive to, and instrumental in, developing a full-time faculty within the JHEP hospitals, the academic versus the practicing approach remains an area of conflict.

SOLUTIONS DEVELOPED

Solutions to the aforemention problem areas revolved around three basic approaches: organizational structure, communications devices and straightforward, educational management.

Organization

As is widely accepted, one of the most effective ways of solving such problems as selection, motivation and acceptance is to involve the participants in self management. This is a very desired end and was accomplished by the establishment of a JHEP faculty organization. Briefly, the organization is composed of two groups. The first is the Faculty Senate, which consists of twenty physicians chosen from the faculty at large. In addition, there is a chairman and vice chairman elected annually. This Faculty Senate comprises the Executive Committee of the Faculty Organization and is responsible for general policy direction and everyday management of the organization. In addition to the Senate, there is the Faculty Council, which consists of all faculty members. Membership in the Council is automatic upon rendering of an academic appointment from the College of Medicine. A more complete description of the Faculty Organization is listed in Appendix II . The activities of the organization consist principally of providing committees for liaison between administration and JHEP in the College of Medicine and the practicing physician. There is in fact a quazi "grievance" committee whose primary responsibility will be to iron out differences of opinion between management and the practicing teacher. The organization has input to the Assistant Dean, thus allowing a degree of self management.

Communications

Productive communications are an absolute necessity for the accomplishment of any task involving more than one person. The problems of communications are compounded when highly individualistic, professional individuals are involved. An effective vehicle for establishing productive communications is the committee system. This system was used quite extensively by the contractor to provide liaison modes.

By way of example, we may scrutinize two committees that have been most productive: the Dean's JHEP Advisory Committee and the Assistant Dean's Advisory Committee. The Dean's JHEP Advisory Committee consists of the Department Chairmen in Jacksonville and thier counterparts in Gainesville. The committee is chaired by the Dean at the College of Medicine. Meetings are held alternatively in Jacksonville and Gainesville. This group provides the forum of exchange of programmatic, budgetary planning, etc. information. Since the group is advisory to the Dean of the College of Medicine, it has policy input on all matters jointly affecting the two institutions.

The second group is the Assistant Dean's Advisory Committee, which consists of the Chairmen of each clinical department in JHEP and his Associate Chairman where applicable. This Committee meets bi-monthly and considers policy and programmatic areas more distinctly limited to Jacksonville programs. Such items as housestaff salaries and fringe benefits, rotations, educational merit of programs in individual hospitals, etc. are considered by this group. In addition, the Assistant Dean's Committee acts as a sounding board for the Assistant Dean and "grievance" committee acting as the interface between the full-time and volunteer faculty.

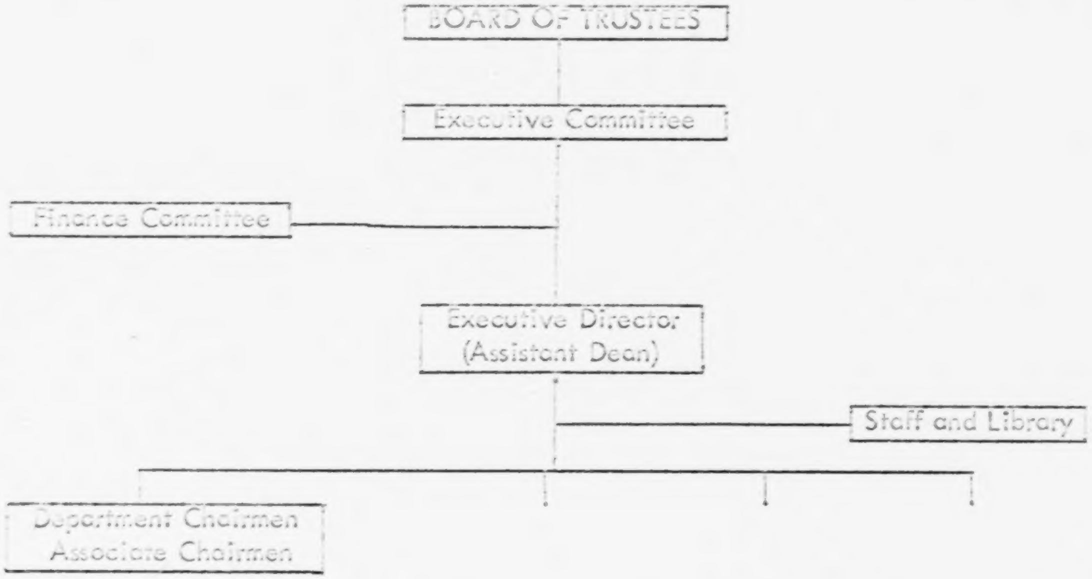
Besidesthese two most active committees, additional modes of communication are utilized. These include a monthly "Newsnotes" which goes to the entire practicing community. "Newsnotes" advises them of local and national issues in medical education as well as reminding them of upcoming continuing educational exercises. In addition, there is a "Faculty Notes" newsletter which is circulated only to the faculty. This periodical maintains information regarding faculty activities and Minutes of the Faculty Senate.

Educational Management

The management of educational endeavors is no different from good management in any other field in that the primary responsibility of leadership is to instill organizational direction in the minds and activities of the associates. That is to say, the responsibility of leadership is to make the faculty visualize their educational goals within the goals of JHEP. Thus, the contractor has directed its planning, objectives and energies toward motivating the faculty along these lines. It is important for the faculty member to realize that hispersonal continuing education can best be served by teaching his peers and housestaff.

The approach in education of defining objectives, identifying problems, formulating plans, allocating resources, implementing and evaluating have often been called "systems analysis" or "educational systems". Though these latter terms are much more in vogue, these same processes of "leadership", or simply effective management. An attempt has been made to practice this in the establishment and activation of the continuing educational faculty. Whenever resources become available, a full-time director of educational systems will be employed to add management expertise in the areas of data processing and communications systems to capitalize on recent and innovative computer applications to the problems of education.

More specifically, the educational management involved in this contract is schematically described by the following organization chart. (The academic relations chart and the composite organization chart are indicated in Appendix 12.)


BOARD OF TRUSTEES
Executive Committee
Finance Committee
Executive Director
(Assistant Dean)
Staff and Library
Department Chairmen
Associate Chairmen

A full statistical description of the faculty was accomplished in order to evaluate the selection process. Out of this survey, it is hoped to gain insight into what will segregate, a priori, the good teacher from the average practitioner.

Additional information regarding the management and communications lines is provided in Appendix 11, the JHEP Policy Manual.

PART III

EVALUATION

Discussion of Contract Objectives

The contract objectives state that the contractor was to train and select a group of 30 to 40 practicing physicians for utilization as a faculty of peer teachers. In addition, the faculty was to devise and conduct continuing education programs and participate in graduate medical education (housestaff).

The simple question of whether the contract objective was accomplished, as mentioned in the preceeding paragraph, must be answered in the affirmative. In fact, the faculty was established and they do participate in graduate education, devise and conduct their own continuing education and that of their peers. In addition, the faculty routinely has input to the College of Medicine in matters regarding the college's relationship with practicing physician in the State of Florida and particularly Northeast Florida.

As alluded to before, however, there is another facet of evaluation which may not be answered as simply. This facet, was the correct faculty chosen and developed. Since the members of the group were subjectively selected, it was considered mandantory that a more scientific appraisal be made of the selection process. Thus, the only valid evaluation, which may be hopefully utilized in other communities, made was the statistical survey of faculty and non-faculty physicians.

Statistical Description of Faculty Versus Non-Faculty

The following represent the results of a study jointly conducted by the contractor and the Medical Sociology Department of the J. Hillis Miller Health Center, University of Florida. Since most items are self explanatory, no discussion is considered necessary.

FACULTY

52% of the faculty believe the strongest dimension of JHEP residency to be the variety of patient/hospitals

40% felt JHEP's greatest need is for more private M. D. participation

92% felt JHEP to be "some" to "great deal" influence on continuing education

Faculty Selection Process

Problem

It is considered apparent from the above survey, that the selection process, utilized by the contractor, was in fact, successful and the best available at the time. The statistics apparently bear out the fact that the most qualified individuals were, in fact, chosen to act as peer teachers. Thus, the primary conclusion regarding selection and establishment of a faculty similar to this and other locales, is that educational leadership must be present in the community. It is considered mandatory that there be an individual, a group of individuals, sufficiently active in medical education in the community, to be able to pinpoint those physicians contributing the most in time to the graduate medical education program. These individuals are "frustrated teachers". The physician, who volunteers time to teach residents, has a built in desire to teach, whether it be housestaff, medical students, or his own peers. It is thus essential, that in establishing a faculty of peer teachers, that this group be tapped.

Change in Educational Behavior of the Community

Because of the establishment of the volunteer faculty, the continuing education activity in Jacksonville rose substantially. From a continuing education field of approximately six non hospital conferences being held per year in the community, the educational enviornment changed to approximately 18 continuing education exercises not based in hospitals, being held. Furthermore, the contractor was able to establish such modes as "mini seminars" held at the hospital medical staff conferences. The great advantage of this, was the availability of the "captive audience". It was found that utilizing this technique and the volunteer faculty, the contractor was able to provide those physicians least likely to attend continuing education courses a close facsimile to the educational value of the course. It is suggested that this would not have been the case without the establishment of a faculty, which is identified and known by the entire medical community and which possesses the "academic cloak".

But perhaps as interesting as this is the fact that, as indicated in the statistical survey, the members of the faculty felt JHEP had been a profound influence in their continuing education. Individual Interviews, with a sample of the faculty, indicated that the primary reason for this had been their establishment as an identified intity, an organizational unit - an identified group.

Perhaps, the best evaluation of the exercise of the contract will be the longitudinal survey of the change in the educational behavior of the practicing physicians. Needless to say, the unstated but overall goal of the contract, and any such similar exercise, is the improvement of patient care. That is the only valid objective of education - change of physician behavior to improve patient care. Such an evaluation could itself take three years and large amounts of time and systems analysis to be statistically valid.

The establishment and development of the full-time faculty, which was supported by the volunteer faculty established under this contract, has also made a significant contribution to the change in education enviornment in Jacksonville. The primary responsibility for the quality and quantity of continuing and graduate medical education in Jacksonville, has been deligated to those full-time faculty members who are Department Chairmen. Thus, the most significant changes in the educational environment are that a mini-medical school is being established, with its complement of research undergraduate medical students and higher quality of housestaff being attracted. Grant proposals have been submitted by the full-time faculty for research in Immunohemotology, sickle cell anemia, orthotic prosthetics, etc. JHEP has been selected by the College of Medicine to provide a large facet of clinical instruction for its

Phase B and C students. This facet of the changed educational environment precipitated in part by the contract to discuss more fully in the final three quarterly reports previously published.

Organizational Changes Brought About by Implementation of the Contract

As alluded to previously, the greatest organizational change wrought by implementation of the contract was the establishment of full-time department chairmen in several of the academic disciplines. In the specialties of: OB-GYN, Pediatrics, General Surgery, Oral Surgery, Orthopaedics, Internal Medicine, full-time faculty with the complete academic appointments were established. These individuals then related to and possessed primary responsibility for graduate and continuing medical education in Jacksonville.

To allow effective communications between the volunteer faculty, JHEP administrations, and the full-time faculty, the faculty organization was established. From its highly energetic beginning, it appears this faculty organization will be a productive group.

Additional organizational changes include the recommendation to the local Medical Society that the JHEP Dean's Society be the standing society committee on medical education. This will again allow liaison between the practicing physician and the academic - both volunteer and full-time - medical community. Promotion committees have been established to as equitably as possible distribute promotions for the volunteer faculty. The group work has been laid through the contract and other activities such as the Long Range Planning Committee Report to make all full-time faculty and house staff employees of JHEP. This will allow the contract to become a separate educational institution, as it were, and proceed with the objective of becoming an educational satellite of J. Hillis Miller Health Center.

Conclusions and Implications for Modeling

It is suggested that in every community, where there is a housestaff program, and the availability of a medical school arrangement for volunteer faculty appointments and leadership that can be identified, a faculty of peer teachers, similar to the one established in Jacksonville, can be duplicated.

Though leadership is of paramount importance in developing a faculty in any other locale, it should be pointed out that the existance of an organization, similar to JHEP, greatly facilitated the development of the contract. The very fact that a consortium of eight hospitals had existed for ten years with at least some degree of success, makes the educational environment fertile enough to plant the seed of a faculty. Additionally, it is apparent through contacts with other centers throughout the nation, that medical schools are becoming increasingly more willing to affiliate with a consortium, rather than any single hospital. The benefits of this are apparent in a broader based political and community support.

PART IV

THE FUTURE

Directly due to the fact of the establishment of the faculty, the contractor began a series of investigations to look inward upon itself to ascertain its real reasons for existance, its statement of objectives and the accomplishment thereof. These investigations resulted in a committee being appointed from the Board of Trustees whose task was to assess current growth and define objectives for long term development.

A summary of the Long Range Planning Committee is attached in Appendix 13. All of the recommendations in the report point to an Area Health Education Center, (AHEC) with the ultimate aim of a health science center located in Jacksonville. There is no question that the reception and development of the contract from Bureau of Health Manpower was the one instrumental factor in laying the ground work for the Area Health Education Center and the future health science center.

In order to make this development orderly and economical, stringent planning will be necessary. Consequently, the contractor is beginning the development of a management information system through which a computer optimization model will be established to simulate the allocation of resources to competing programs facets. The plan will be to seek Federal or private funding of this project which should last three to five years. See Appendix 14 for a summary of the computer model to be developed.

ARTICLE I. Scope of Work

A. The Contractor shall furnish the necessary personnel, materials, equipment and facilities to develop a program of graduate and continuing education for practicing physicians in the Jacksonville, Florida Metropolitan Area in cooperation with the College of Medicine of the University of Florida. In pursuance of the foregoing, the Contractor shall specifically:

1. Select and train a faculty of thirty to forty practicing physicians from the Jacksonville Metropolitan area at the College of Medicine, University of Florida or other appropriate medical teaching facility. Training of these physicians shall be directed to:

   a. Increasing knowledge of their specialty.

   b. Acquainting this faculty with medical school teaching activities.

   c. Faculty responsibilities as medical school staff appointees.

2. Devise and conduct a continuing educational program for graduate and practicing physicians using the faculty in 1. above.

3. Utilize consultants in the fields of education, behavioral science, sociology, and medicine to determine ways of analyzing the:

   a. Effectiveness of the program as a means of continuing education in the Jacksonville "faculty."

   b. Evaluation of each faculty member as a teacher and the effect of his participation in the program upon his effectiveness as a practicing physician.

   c. Identification of new techniques of continuing education to be explored in greater detail.

   d. Implementation and evaluation of new techniques identified in c. above.

4. Develop a format for potential use for continuing education of practicing physicians based upon this method of cooperation between a medical teaching facility and physicians of a metropolitan area.

B. In connection with and as a part of the work and services to be performed hereunder, the Contractor shall furnish to the Project Officer, the following reports:

1. Quarterly progress reports (original and four copies) which shall give an account of work accomplished to date, important problems encountered, solutions to these problems, and proposed work plan for the coming quarter.

ARTICLE I. Scope of Work (Continued)

2. A final comprehensive report (original and four copies) which shall specifically:
   a. Describe the method of selection and training of the practicing physicians who become the faculty in the Jacksonville area.
   b. Identify the methods and techniques employed by this faculty in the conduct of the continuing education activities.
   c. Critique and assess the effectiveness of the various activities used in 2-b. above.
   d. Prepare a proceedings of the ad hoc evaluation conferences.
   e. Submit a recommended format for possible use in other areas for continuing education.
3. Patent Disclosure Reports (See Patent Rights Clause of Contract).
4. The work required hereunder does not include the use of plans or report forms which require Bureau of the Budget Clearance. This contract is in support of research or other general purpose and not for the specific purpose of obtaining the information which may be collected through the use of plans or report forms. The contractor, or any subcontractor hereunder, collecting information on his own initiative in connection with this contract must not in any way represent that the information is being collected by or for the Bureau of Health Professions Education and Manpower Training, NIH, Department of Health, Education and Welfare.

ARTICLE II. Period of Performance

Performance of this contract shall begin on December 15, 1968, and shall not extend beyond the completion date of December 14, 1970, unless the period is extended by modification of the contract.

ARTICLE III. Compensation

A. Maximum Actual Cost

1. The actual cost to the Government, including all direct and indirect costs, for the performance of this work shall not exceed the estimated cost of SEVENTY THREE THOUSAND FIVE HUNDRED AND NO/100 DOLLARS ($73,500.00), and the Contractor agrees to use its best efforts to perform all work and all obligations under this contract within this estimated cost and the period of time set forth in Article II.

JACKSONVILLE HOSPITALS EDUCATIONAL PROGRAM, INC.

DOCUMENT OF AFFILIATION

I OBJECTIVES:

A decade ago the Jacksonville Hospitals Educational Program (JHEP) was established with the purpose of strengthening the existing programs of graduate medical education and developing new ones in the participating hospitals. Continuing Education for physicians promptly became integrated into this program. These two features are still the prime objectives of JHEP. During the intervening years, the Jacksonville medical community advanced its potential as a resource for education and patient care. Also, the Duval Medical Center, because of its patient population, its involvement with the community and its large staff of qualified, full-time personnel became the focal point for many areas of educational programs. Concurrently, the College of Medicine at the University of Florida developed a more meaningful relationship with JHEP. In addition, the Regional Medical Programs of the North Florida area is utilizing JHEP as an agent. In view of the increasing need for expanding opportunity for the education of the physician at every level; in view of the increasing need for medical personnel in the community; and in view of the potential resources in the Jacksonville medical community, JHEP and the J. Hillis Miller Health Center of the University of Florida have agreed:

> To design a plan for the development of JHEP as a division of the Health Center of the University of Florida, with increasing involvement of that division in all phases of health education.

In order to accomplish this objective, the following will be undertaken:

- a. Formalize and strengthen the affiliation between the two agencies.
- b. Establish an effective faculty and administrative structure within JHEP.
- c. Seek a legislative mandate for this program and establish appropriate mechanisms for funding.

II ORGANIZATION:

A. The hospitals and their medical staffs participating in JHEP delegate to this organization responsibility and authority for planning, implementing, recruiting for, coordinating and evaluating programs in medical education. JHEP will, in turn, assume the following functions:

1. Establish standards for evaluating and approving educational programs and research endeavors and set priorities for implementation of new programs.

2. Seek funds for the support of its program.

II ORGANIZATION: (cont.)

3. Act as a division of the Health Center of the University of Florida, utilizing Duval Medical Center and other properly constituted organizations as the major foci of teaching activities.

4. Recruit outstanding teachers for the community.

B. Membership

Hospitals and their medical staffs in the City of Jacksonville who fulfill the following requirements may become members of JHEP: educational activity and commitment to continuing support of JHEP through staff activity, financial contributions and space. These criteria will be reviewed by the Board of Trustees of JHEP.

C. The Governing Board of JHEP

The Governing Board and its Executive Committee are constituted as specified by the by-laws. The Board may appoint, as the need arises, committees of its members and other qualified individuals such as Finance Committee and a Professional Affairs Committee. The Board delegates to the Dean of the respective college responsibility for all academic programs of JHEP.

D. College of Medicine

1. Director of JHEP and Assistant Dean for Jacksonville Programs.

The Director assumes responsibility for the implementation of the educational programs of JHEP through the clinical departments of JHEP. He reports to the Board of JHEP and to the Dean of the College of Medicine. His appointment is presented for approval to the Board of JHEP and to the Provost of the Health Center and President of the University of Florida jointly by the President of JHEP and the Dean of the College of Medicine. This must be approved by the Board of Regents. He must be a full-time employee of the University of Florida at JHEP, with qualifications for faculty appointment at the University of Florida. Similar mechanisms may be used for other colleges of the Health Center for their respective programs.

2. Clinical Departments and Faculty Relationships with the College of Medicine

The JHEP departments consist of those physicians who participate in the JHEP program and who may have academic appointments in the College of Medicine. These may be full or clinical appointments. The Chairman of each JHEP academic department shall be appointed from the full-time members who at the present time are located at the Duval Medical Center.
Upon the recommendation of the respective Department Chairman at the College of Medicine, the Assistant Dean, in consultation with his Advisory Committee, nominates the Chairman of each JHEP Clinical Department. This appointment is presented to the JHEP Board for approval following which it is forwarded to the Dean of the College of Medicine for action. It must be approved by the Provost of the Health Center and the President of the University of Florida.

D. College of Medicine (cont.)

2. Clinical Departments and Faculty Relationships with the College of Medicine (cont.)

Other appointments to the faculty of the College of Medicine will be made in the following manner. Those receiving full appointments will be selected jointly by the Chairman of the Department at JHEP and at the College of Medicine. Their appointment is recommended to the Dean of the College of Medicine by the Assistant Dean for JHEP and must be approved through normal university channels. Those appointees will come from full-time physicians in the Jacksonville community.

Those receiving clinical appointments will be those attending physicians in the participating hospitals who are active in the JHEP teaching programs. Their nomination for appointment will be made annually by the JHEP Department Chairman in consultation with his Associate Chairman. These must be approved by the Chairman of the Department at the College, the Assistant Dean for JHEP, by the Dean of the College of Medicine, and by the Provost.

The JHEP Department Chairman will relate to the participating hospitals through their elected Chiefs of Service. An Advisory Committee for the Department Chairman will be composed of these Chiefs and other physicians as may be appointed by the Chairman.

Each JHEP Department Chairman will appoint an Associate Chairman from the voluntary faculty. He will be selected from a list of three physicians recommended by his Advisory Committee. This Associate Chairman will be approved by the Department Chairman of the College and the Assistant Dean. He will advise and assist the Department Chairman and serve on the Assistant Dean's Advisory Committee.

Working with his Advisory Committee, the JHEP Department Chairman will be charged with the responsibility of identifying and developing those unique features of each member institution which might serve to enhance and expand the educational programs.

The JHEP Chairman carries the major responsibilities and authority for planning, implementation and supervising the educational program in his discipline. For this purpose he works with the Chairman of the respective department in the College of Medicine and seeks from the Assistant Dean support and approval of his decisions and actions.

3. Dean's Committee

The Assistant Dean shall have an Advisory Committee consisting of JHEP Department Chairmen, Associate Chairmen and others that he might appoint who will aid in implementing the program.

III PROGRAMS OF THE COLLEGE OF MEDICINE:

There are essentially three major programs in which JHEP should be involved: graduate medical education, continuing medical education for the practicing physician and undergraduate medical education. In addition, JHEP should assist in developing programs in other health professions.

A. Graduate Medical Education (Interns and Residents)
Each JHEP department will review all existing programs in its area, assess their quality and potential, and prepare a realistic plan for future action, utilizing fully all educational resources JHEP offers through its participating hospitals. Such plans must be approved by the Assistant Dean and the Chairman of the respective department in the College of Medicine.

B. Continuing Medical Education
The Director of JHEP should make every effort to organize an effective program in continuing medical education in the Jacksonville area and its surrounding counties. It is desirable that such programs assume as much independence as possible, but also relate closely with the College of Medicine at the University of Florida and with the Regional Medical Program.

C. Undergraduate Medical Education
Plans should be made so that JHEP may offer opportunities for undergraduate medical students in their clinical training. This may become necessary once the medical student class at the College of Medicine has increased in size. It seems most important that the JHEP faculty members utilize the particular characteristics of its resources in such a fashion as to design educational experiences which cannot be offered by the College in Gainesville. This relates especially to all facets of community medicine in urban areas.

IV OTHER EDUCATIONAL PROGRAMS:

It is most desirable that JHEP should concern itself with educational programs in other health profession areas such as Dentistry, Nursing, Health Related Professions and Pharmacy. It is recommended that the Assistant Dean assist in developing such programs with appropriate Dean at the J. Hillis Miller Health Center and with other regional educational resources.

V FINANCING:

The financing of JHEP will be the responsibility of the Board of Trustees. The available funds will be administered by the Executive Director within the framework of approved budgets and financial policies set by the Board of Trustees. The financing of JHEP sponsored programs must come from a variety of resources such as:

a. Participating hospitals
b. State of Florida
c. Federal government
d. Private practice funds generated by faculty members
e. Other sources

FINANCING: (cont.)

The Dean of the College of Medicine and the Assistant Dean are responsible for preparing a budget and for the administration of available funds. The Board of Trustees will determine the contributions by the participating hospitals of JHEP.

VI This Document may be amended and/or altered by the same mechanism used for its approval.

August 27, 1969

Approved by the JHEP Board of Trustees on August 27, 1969.

Approved by the Florida State Board of Regents on October 3, 1969.

SALARIED AND VOLUNTARY STAFF--THE INTERFACE

by

Max Michael, Jr., M. D.
Executive Director
Jacksonville Hospitals Educational Program
Jacksonville, Florida

"Interface" has certain interesting connotations as concerns our topic for discussion. It is defined as a boundary between two phases of a heterogeneious system. Consider if you will, the interface between·milk and cream. These two substances remain separated with a readily observable interface unless shaken vigorously or homogenized. This traumatic action changes the easily observable interface into an imperceptable dispertion of particles; the interface persists but it is invisible and "smooth". Let us keep this analogy in mind when we consider the desiradum at the interface.

The number of salaried full-time staff physicians has increased rather rapidly in community hospitals, independent of an association with a medical school. As to be anticipated, certain problems have arisen at the interface between the salaried and volunteer staff. The conflict at the interface is neither new nor endemic solely to physicians. It has existed historically as the conflict between "practitioner" and "teacher," no matter what profession or activity.

Before attempting to enumerate some of the problems, I shall indicate some of the causes for their existence, i.e., etiologies. Some of these, and in no specific order, are the following. First is the lack of a defined role for the salaried staff, i.e., planning. Just why are they there? Why has this come about? Is it just because this is the fashionable thing to do--that every hospital must have full-time people? Are they purely to render service? Are they there to recruit housestaff? Are they there to develop continuing education programs? Are they there to capture the hospital, wrap it in a tidy package and present it to the medical school? Are they there to tend the store while the practicing physician runs his practice and lets the salaried physician run the hospital, its committees, and its staff? Or, finally, indeed, is the salaried physician there to develop meaningful educational programs at all levels? I think the last is how most full-time staff would view their role, but all too often they were recruited for other reasons and the lack of role definition has created some of the trouble.

Another facet of lack of role definition is the absence of a clear statement as to how they fit into the organizational structure of the institutions. How, in fact, do these persons fit into the composition of the hospital? It's astounding to consider the number of full-time physicians who have been recruited without a clear indication as to what they will do and how they will fit into the hospital organization. Are they the chief of service or do they come in with some title as director of research and education? This ploy avoids the real conflict that is bound to occur. Do they sit on the executive medical staff? Do they relate directly to the department chairman of the medical school or does one of the voluntary men so function? Usually the voluntary staff begins the negotiations with the medical school and often considers it its prerogative to continue in this role. Thus a nebulous organizationsl structure, without clear definition as to where the salaried man fits into the hierarchy of the hospital is an area that can generate significant problems.

Another itiology I have called the conflict of values, for want of a better term. The private practitioner is very prompt to say that his sole responsibility is the patient--he comes first. And, indeed, he is correct. On the other hand, the salaried physician, often going to the community hospital direct from a medical school, has as his primary goal teaching and research. Patient care, motivated solely to cure the patient is frequently alien to him. There results a conflict of values, or more realistically, a different assessment of priorities. Another type of conflict of values is the utilization of one's free time. The man fresh from the "academic institution" will take off a few hours on a Tuesday afternoon to read in the library. The private practitioner can't give himself this luxury.

There is another source of trouble, the competition for the dollar--and the dollar comes from patient service. There will eventually be a certain degree of competition for practice and consultation fees.

And finally, for want of a better term, "ego and envy" may cause problems. The grass is always greener on the other side of the street and each group is envious of the other and each group feels that his ego is being trampled on by the other.

These are some of the basic causes of problems. It is prudent at this time to examine how the problems that have been generated are manifest. There is mutual distrust and misinterpretation of actions. This results in what I call: "the hostility syndrome". For example, the salaried physician may not be in his office on Saturday morning to answer the phone. Rather he may be working in his laboratory as this is the one day that it is quiet and conducive to thoughtful pursuits. But the busy practitioner who is tending to the problems of his patients on a Saturday is unable to comprehend this. The salaried physician goes away to more meetings than the nonsalaried individuals. There may be committee work, study sections, scientific program or the like. The commitment to these, is, at time, difficult for the practitioner to understand. Hostility often results.

Another manifestation is the diminishing participation of the voluntary or nonsalaried physician in educational programs, be it at the graduate or the undergraduate level. This comes about for various reasons. Often it happens because the voluntary staff member breathes a sigh of relief and exclaims, "now we've got full-time people; they can do all the work; let Joe do it". This is not new. This didn't just happen when the full-time clinicians appeared. It began when the first director of medical education arrived on the scene. The tendency of staff to let him take over the entire operation and for them to retreat into the sinecure of practice often brought disastrous results. This attitude is not only a problem in the area of teaching--it's a problem of all aspect of operation of a hospital. And, this results in what I call the "squeezed out" or the "Anschluss syndrome." This fear of being squeezed out is something that must be carefully guarded against, though it may often be initiated by the staff itself. Particularly is this so if the voluntary faculty is to be utilized in teaching. That their participation is not only desirous but necessary is patently clear.

There is another manifestation of the problems and let's call that "academic arrogance" syndrome. This refers to the ploy of the salaried physician looking down his nose in an imperious fashion at the "poor misguided soul who makes his living taking care of the sick." The salaried men quite often do not understand the nature of private practice. They may be given to derision at the way the private physician treats his patients. "He is quick to prescribe medicine", and often he is. He doesn't spend enough time with patients or he spends too much time with them. There, by the same token, the practicing physicians look down his nose at the salaried man and says, he's not practical; he's not in the practice of medicine and he doesn't know how to do it. There is truth on both sides, but isn't it amazing to witness the divergent paths of people exposed to the same initial environment? All of these result in a new type of town and gown syndrome. I'm sure many of your recall a paper given at the Congress on Medical Education a few years ago on the town-gown syndrome. It spoke of the ivory tower of the medical school vis a vis the ivory tower of the practicing community. This "towerism" results in a mutual distrist between the practitioner and the teacher. Now we are rapidly developing a new type of town-gown syndrome. The only difference between this and the traditional one is that the new type occurs within the same institution. It is intramural. The same fears, hostilities and anxieties exist. This can result in an enormously difficult situation: each group retreats within its own ivory tower, communications cease, patient care and medical education suffer.

We've addressed ourselves to the problems that can arise and to some of the manifestations. I've attempted to indicate some of the causes. Are there solutions, and if so, what are they? It is quite clear that there can be no solutions until the existence of the problem is admitted. Ideally, the best method to avoid problems is to prevent them, and planning is the key. Each institution will thus have to plan and solve individually.

However, some guidelines can be ennumerated. Let us examine some of the things that make for a smoother interface between the salaried and the non-salaried physicians. Keeping open channels of communications is essential. When the full-time staff structure, changes in agreements with medical schools, it is essential that the voluntary staff be apprised of events and involved in the decision making.

There are a number of committees in which representatives of each group should participate. This includes those that deal with education, with patient care evaluation, and if indicated, with relations with medical schools.

The problem of handling of practice fees has been alluded to. There must be some type of rational and fair system for the handling of fees generated by the salaried physicians. It is knotty but must be considered. I refer not only to a mechanism for handling these fees, but also a mechanism for determination of incomes. There must be some sort of ground rules to prevent the salaried physician from spending his time generating funds for his personal use at the expense of his teaching activities. And just as important he must not be forced to spend significant amounts of time to earn his keep. Confusing, but true!

Another consideration is the identification by the salaried staff of the leaders in the voluntary staff. This can be quite helpful in assigning the specific roles to help bring the voluntary staff more into the teaching picture. Finally, mutual understanding and empathy can go a long way towards being a panacea.

We have considered many of the distasteful things that might accrue from our interface. But, we have not considered the good things. It is assumed, and rightly so, that the interface between the salaried and the voluntary staff will result in better education at all levels, and, hopefully, in better patient care. And, indeed, that is the name of the game.

CONFLICT AT THE INTERFACE

PROBLEM	CAUSE
Distrust and misinterpretation of actions	Lack of role definition and responsibility relationships
Lack of mutual understanding and respect	Differing priorities
Squeezed out	Lack of productive communications
The dollar	Role definition; unsatisfactory mechanisms for handling fees and salaries

CURE (Prevention)

Role definition

Planning for full-time persons

Communications

I have tried to outline some of the problems at the interface between the salaried and the voluntary physician and some of their causes. If one can remain alert to the fact that they can arise and can attempt to understand their causes, then one can develop preventive measures. May I suggest some general preventive measures--role definitions, mechanisms for reacy communications involving teacing and decision making and a realistic approach to handling of private practice fees.

Whether the interface between salaried and volunteer staff is smooth and imperceptible as the finely homogenized suspension of milk and cream, or turbulent and disparate depends of many things. Foremost is a recognition that problems can arise, that there are specific causes of these problems and that much can be done to prevent turbulence. Patience, tact and understanding need to be used to a large degree.

Reprinted From the [illegible] Association
December 13, 1971 Volume 218
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Phasing Out the Freestanding Internship

Max Michael, Jr., MD

Change of any type—be it in the weather, in politics, in organizational structures or, in our instance, in educational patterns, calls for readjustments and realignments. Changes are accompanied by resistance and hostility on the one hand and by drive and enthusiasm on the other. Those changes that are evolutionary rather than revolutionary are usually more readily accepted. We are concerned with changing patterns in medical education and, germane to this discussion, with changes in the internship. As I will attempt to show, these changes have been evolutionary and, hence, should be more palatable than they seem to be.

In June, 1970, the AMA House of Delegates adopted two recommendations of the Council on Medical Education; to wit: (1) After July 1, 1971, a new internship program shall be approved only after the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole. (2) After July 1, 1975, no internship program shall be approved which is not integrated with residency training to form a unified program of graduate education.

No actions in recent years have generated more emotionalism, debate, recriminatory remarks, and misunderstanding than these. If the logic behind this move is clearly understood and if an historical perspective of the evolution of the internship can be kept in mind, then these feelings can be obviated. I beg your indulgence in a brief historical review of the internship for it will help to understand the evolutionary changes that have transpired. For a comprehensive overview, the excellent report by Campbell is recommended.[1]

The internship came into its own in the early years of this century when it was realized that upon graduation, the student would be better equipped to practice medicine with a year of greater responsibility and clinical experience. By 1915, seventeen states required an internship for licensure. Toward the end of the second decade, the first *Essentials of an Approved Internship* was published. This was the result of a survey that pointed out the many deficits in graduate programs. Standards were thus set. The Internship Review Committee, a committee of the Council on Medical Education, came into being as the approving body. In the 20's and 30's, there was a proliferation of specialties, each with its own certifying board. The internship review committee remained separated from these bodies. Internships were rotating for the main part—indeed, revolving would be a better description for many of them. Later, the trend toward straight internships developed. But still, these were separate, oftentimes fragmented, lock-step programs. Dr. Willard Rappelye, Chairman of a Council on Medical Education of the Association of American Medical Colleges (AAMC), reported the following in 1927:

> . . . an internship should be required before a license to practice is granted but it is educationally unsound to require that all graduates shall have the same type of hospital service. Standards, rather than standardization, should be the aim . . . should provide a variety of opportunities to meet the educational needs, previous preparation, and life programs of different individuals. There should be variety and flexibility in the appointments . . . medical schools should take a more direct interest, helping to formulate sound programs of training for interns in teaching as well as nonteaching hospitals.

One of the more significant changes in the rotating internship occurred in 1966, when a wider latitude of program choice was open to the graduate. But this program, again, is not often correlated with training of later years. And again, standards for the intership and approval thereof were under the direction of the Internship Review Committee which did not concern itself directly with residency programs.

Two highly significant events of recent years provided new impetus for a fresh look at the internship. First are the recommendations of the Citizens Commission on Graduate Medical Education, whose presentation is the storied Millis Report. In referring to the fragmentation of medical education, the statement was made that ". . . any program of graduate medical education should be planned as a unified, progressive sequence. It is not so today. Instead, it is two separate stages—an internship and a residency—and the connection between the two stages is too loose." With very few exceptions, the specialty boards have not indicated the nature of the required internship nor have the program directors in the various specialties had an input into the usual rotating internship. Thus, it has too often been freestanding without educational continuity into the residency. When it was customary for the graduate to take one year of internship and then enter practice, perhaps this unattached internship was adequate. At the present time, with additional years of postinternship education almost universal, this is no longer tenable. The Millis Report then recom-

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From the Jacksonville Hospitals Educational Program, Florida; and the College of Medicine, University of Florida, Gainesville.

Read before the 67th annual Congress on Medical Education, sponsored by the AMA Council on Medical Education, Feb 15, 1971.

Reprint requests to 2000 Jefferson St, Jacksonville, Fla 32206 (Dr. Michael).

[illegible] . . . that the internship, as a separate and distinct portion of medical education, be abandoned and that the internship and residency years be combined into a single period of graduate medical education called a residency and planned as a unified whole."

The second event of note is the change in medical school curriculum. In addition to the rather spectacular changes in the traditional basic science instruction, there is emphasis in the latter years on flexibility. Large blocks of time are made available for electives. This means that we will no longer have graduates of the same mold. The cookie cutter has been discarded and graduating students will arrive for their period of "post MD" education with diverse backgrounds of information and experience. I would point out that Shulman, in commenting on the principles of medical education, stated that one should set levels of achievement as a constant and keep time as the variable.[2] Perhaps the various certifying boards will take such an imaginative step in the future and if, indeed, such does transpire, it will be even more essential to keep the first year flexible.

These developments mean that the internship, or the first postgraduate year, if you will, can no longer furnish lock-step programs. In essence, the internship year can no longer be freestanding. It must be made flexible to take into account the medical school experience and, even more important, the career goals of the physician.

It should be apparent then, that the aforementioned action was not the result of the capricious and precipitous conclusions of a few. Rather, it was the result of much study and deliberation on the part of the Council on Medical Education and its Advisory Committee on Graduate Medical Education.

Other bodies concerned with medical education had considerable input and the staff of the Council on Medical Education labored mightily in amassing data, in sampling opinions, and in collating information.

It is prudent at this stage to identify precisely what is meant by a freestanding internship. What is it that is being phased out? Two examples can be cited. The first are internships in hospitals with no residencies and with no relationships with other hospitals having approved residencies. These programs are most often service oriented and bear little resemblance to the educational pattern that is needed. Because of service requirements of the institution, the programs are usually stereotyped and cannot conform on an individual basis with the needs of the student. Obviously, they cannot mesh with a residency if none exists in the institution.

The second are those in hospitals with approved residencies but in which the internship is not coordinated with residencies in that or any other hospital. In this type of program, there are frequently straight internships within the same institution. The straight interns relate to their department and mesh with the totality of the program. The rotators, however, are vagabonds—they have no firm alignment except for the brief time in each service. They indeed have no home base and most often have no plan which would coordinate this year with training of subsequent years. Clearly, these types of internships represent glaring examples of programs in graduate medical education that have been criticized; they are fragmented from the whole and do not integrate well with the pattern of medical education.

The alternatives for such programs are clear—either abandon them or integrate them into the mainstream of medical education. In the first instance, that is, internships in hospitals with no residencies, this means either developing residency programs in those institutions (and we have a surfeit of residencies at this stage) or integrating them closely with ongoing residency programs in other institutions. If this latter pathway is taken, it must be realized that the program director for a residency with which the graduate plans identification, must be actively involved in planning for the educational experience for this first year in order that a smooth transition into the latter years is preserved.

Equally as important as what the actions mean in a positive fashion is an understanding of what they do not mean. It does not mean that the rotating internship is being [illegible] it is being made more flexible and is being integrated into the totality of graduate education. It does not mean that internships in hospitals without a medical school affiliation are being abolished—this may be an ultimate goal of some but the mechanics as to what constitutes a true affiliation remain rather nebulous. It does not mean that family practice programs are being abolished—far from it—this first year is being clearly integrated with existing family practice programs. It does not mean the term "internship" will be abolished. Indeed, it might be desirable to call this the first postdoctoral year, particularly since some specialty boards no longer require an internship. For the present, however, for reasons of licensure and for sake of certain sentimental attachments to the term, the name internship will persist.

Another disclaimer is in order. This concerns the effects of these moves on individual residency programs. In no way is this to interfere with the requirements set out by the various residency certifying boards. This ~~is~~ clearly stated in one of the interpretive sentences, ". . . Even though the certifying board in the specialty concerned does not require an internship, the program director would still have the option of specifying an internship year." Clearly though, this point indicates strongly the need for true corporate responsibility for medical education.

Comment

I have tried to indicate that the changes to be accomplished in the internship represent the results of study and debate. The decisions were arrived at by evolutionary means, taking into account the entire changing picture of medical education. I think it prudent to avoid the statement "phasing out the internship." More appropriately, we should say that the internship is being "phased into" the mainstream of medical education to make it an integral part of the continuum of medical education that we seek.

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2. Shulman LE: Cognitive learning and the educational process. *J Med Educ* **45**:90-100, 1970.

Printed and Published in the United States of America

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2. Emphasis on potential of T.V.
3. Methods of individual physician making his own slides for medical educational purposes. " Instatek " by Kodak on "visual maker" by Lester Dyne.
4. Need for local audio-visual library rapid retrieval for continuing education.
5. Expense, practicality, ease of developing sound synchronized slides for continuing education.
6. Practicality and future of closed circuit T.V.
7. 8 mm. cartridge most reliable, practical, expedient version of audio-visual aid in use for Continuing Education, Patient Education, Rehabilitation.
8. Possibility of Audio-visual Department in JHEP to serve local community
9. Compressed speech application.
10. Promises for the future in audio-visual
    a. Physician - computer hook-up by visual phone (data link)
    b. Color EVR cartridges received by subscription, weekly, to be played at office on T.V.
    c. 3-D techniques and applications.

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1. Instamatic 304 with kit "visual maker" to take pictures of magazine illustrations, articles, etc. Price: $ 115.00
2. "Instatek" by Lester Dyne, to take clinical pictures of patients in the physician's office. Price: $ 50.00
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4. 8 mm. cartridges. 5 minutes long in sound and color. Single subject - reproduction machine cost. Approx. Price: $ 135.00

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CONFERENCE WILL PROVIDE	% RESPONDENTS
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Specific change in practitioner behavior	55%
Applicability of material was	
minimal	10%
average	45%
high	45%

IMPLEMENTATION METHODS

for presentation
to

WORKSHOP
on
INSTRUCTIONAL
STRATEGIES
on
MEDICAL
EDUCATION

by Norman E. Tucker, P.E.
Presented June 6, 1970
Jacksonville Hospitals Educational
Program
Jacksonville, Florida

JACKSONVILLE HOSPITALS EDUCATIONAL PROGRAM
Instructional Strategies

June Workshop

1. As an instructor in the Jacksonville Hospital's Educational Program, what do you see as your main purpose?

2. As an instructor, give an example of a specific question you would like to have answered in the course of this workshop.

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ACKNOWLEDGEMENTS

The material packaged into this "handbook" is the composite of items gathered by the author throughout several years of training studies and activities coupled with special submissions for this Workshop. My sincere thanks go to (1) Joseph Scottino, Ph.D., of Gannon College for the Centered Oriented Methods, (2) Ronald Richards, Ph.D., of Michigan State University for the Physician Oriented Methods and "Dimensions of Instruction," (3) George Miller, M.D., of the University of Illinois College of Medicine for his instruction to me on The Lecture during one of his famous "Instructional Skills Workshops," (4) Instructors School, Fort Belvoir, Virginia, for the brow-beating (and associated information utilized here) they gave me some years ago and, also, for the best course in Instructor Training any United States Army Officer could get, and (5) to Max Michael, Jr., M.D., Executive Director, Jacksonville Hospitals Educational Program for the opportunity to make this presentation.

Norman E. Tucker

PREFACE*

Once upon a time a Sea Horse gathered up his seven pieces of eight and cantered out to find his fortune. Before he had traveled very far he met an Eel, who said,

"Psst. Hey, bud. Where 'ya goin'?"

"I'm going out to find my fortune," replied the Sea Horse, proudly.

"You're in luck," said the Eel. "For four pieces of eight you can have this speedy flipper, and then you'll be able to get there a lot faster."

"Gee, that's swell," said the Sea Horse, and paid the money and put on the flipper and slithered off at twice the speed. Soon he came upon a Sponge, who said,

"Psst. Hey, bud. Where 'ya goin'?"

"I'm going out to find my fortune," replied the Sea Horse.

"You're in luck," said the Sponge. "For a small fee I will let you have this jet-propelled scooter so that you will be able to travel a lot faster."

So the Sea Horse brought the scooter with his remaining money and went zooming thru the sea five times as fast. Soon he came upon a Shark, who said,

"Psst. Hey, bud. Where 'ya goin'?"

"I'm going out to find my fortune," replied the Sea Horse.

"You're in luck. If you'll take this short cut," said the Shark, pointing to his open mouth, "you'll save yourself a lot of time."

"Gee, thanks," said the Sea Horse, and zoomed off into the interior of the Shark, there to be devoured.

The moral of this fable is that if you're not sure where you're going, you're liable to end up someplace else.

---

*Preface from "Preparing Instructional Objectives" by Robert F. Mager

TYPES OF LEARNING

1. PSYCHOMOTOR
2. AFFECTIVE
3. COGNITIVE

TYPES OF LEARNING

In the preparation for any learning experience, one must be cognizant of the three basic types of learning and consider which of these will be employed.

The first of these types is PSYCHOMOTOR. Since, by definition, psychomotor is of or related to muscular action, this type of learning employs physical activity to learn such as for teaching a skill or as in sports.

The second type is AFFECTIVE learning or that learning which is primarily predicated upon the attitudinal aspects.

The third type is COGNITIVE learning which is factual in nature.

Since learning may be defined as "advancing beyond where you are" (as compared to the traditional definition of "to gain knowledge or understanding of or skill in by study, instruction, or experience"), then teaching must be the "means by which you advance" which then becomes the study, instruction, or experience gain. More specifically, teaching is "imparting information."

This brings us to the means for imparting this information or the Implementation Methods.

IMPLEMENTATION METHODS

1. PATTERN ORIENTED METHODS
2. CENTERED ORIENTED METHODS
3. CATEGORICALLY ORIENTED METHODS

PATTERN ORIENTED METHODS

1. The Lecture Method - talk to
2. The Discussion Method - talk to and talk back
3. The Laboratory Method - direct experience
4. The Project Method - assignment to student
5. The Recitation Method - assignment, study and report
6. The Problem Solving Method - research type
7. The Activity Method - group dynamics as workshops and role playing

CENTERED ORIENTED METHODS

1. Teacher Centered
    - a. Lecture
    - b. Illustrated Lective
    - c. Questions and Discussion
        - (1) Leading
        - (2) Open Ended
    - d. Drill

2. Student Centered
    - a. Recitation
    - b. Student Reports: Oral, Written
    - c. Supervised Study
    - d. Independent Study

3. Process Centered
    - a. Discovery
    - b. Problem Solving
        - (1) Deductive
        - (2) Inductive
    - c. Demonstration
        - (1) Student
        - (2) Teacher
    - d. Case Study
    - e. Role Playing and Sociodrama
    - f. Project

    - g. Model Building
    - h. Micro Teaching

4. Media Centered
    - a. Bulletin Board and Displays
    - b. Laboratory
    - c. Slide Projection
    - d. Audiotape
    - e. Videotape
    - f. Television: Open and Closed Circuit
    - g. Computer Assisted Instruction
    - h. Programmed Instruction
    - i. Library as a Learning Resource
    - j. Learning Materials Center
    - k. Utilizing Community Resources

CATEGORICALLY ORIENTED METHODS

PHYSICIAN ORIENTED METHODS

1. INFORMAL ROUNDS OR CONSULTATION
2. DIDACTIC PRESENTATION (lecture or other)
3. CASE STUDY
4. FORMAL ROUNDS
5. SIMULATION

1. INFORMAL ROUNDS OR CONSULTATION

The instructor in this situation would meet with the physician and serve as a consultant on some of the patients that he is having problems with. This informal interchange provides an opportunity for the instructor to interact with the physicians in terms of their own problems, and together they can identify what the physicians need to improve their own practice of medicine. This is the developmental stage.

2. DIDACTIC PRESENTATION (lecture or other)

Following step number one it may well be appropriate to have some lecture presentation, a film, a panel discussion, some slide presentations or other didactic method.

3. CASE STUDY

In this method of instruction I would favor having the cases developed perhaps by the physicians themselves, or a group of physicians, and then be brought to perhaps a Saturday morning session in which other community physicians look at the case, consider them and the experts can assist in the discussion. This sort of technique gets the community physician involved in the instructional process early and his learning will continue after the Saturday morning conference is completed.

4. FORMAL ROUNDS

This is a return to the real situation and takes advantage of the motivations of the physician to deal with problems that are his own. This sort of technique takes more time. The number of students that an instructor can deal with at any one time is smaller, but I firmly believe that the instructional payoffs will be much higher in terms of the changes in the manner in which medicine is being practiced.

5. SIMULATION

In some instances, particularly when issues of attitudinal changes and other aspects of making decisions about the management of patients are involved, a simulated situation might be created in which the physicians get together and explore a simulated problem. This instructional technique is most effective when the instructor who is guiding the simulation is able to induce effective discussion about the experiences the physicians have had in the simulation.

There are many other methods and I'm sure that you are probably as familiar with them as I am. In conclusion, of the many many methods of instruction it is particularly important that the instructor be assisted in making decisions about which method to use. These decisions are based upon certain characteristics of the instructional process rather than the inherent value of any method of instruction.

THE ACTIVITY OF TEACHING

1. GOALS
2. PROCEDURES
3. CONTENT
4. METHODS
5. INTERACTION
6. EVALUATION

Once the "teacher" decides he will attempt to "teach" his students something, several kinds of activity are necessary on his part if he is to succeed and fulfill the responsibility which he has accepted. These activities are identified by the six "clue" words in the table entitled "The Activity of Teaching."

The instructor must first decide upon the goals he intends to reach in the time allotted to him. These objectives should be well written on an appropriate "Lesson Plan."

He must then select the procedures he plans to employ to reach these objectives.

Next the content and the methods which are relevant to these goals must be identified and prepared for employment in the teaching exercise.

At the appropriate point(s) in time as the experience progresses, the "teacher" must cause the student to have an interaction with the subject matter in accordance with principles of learning.

Finally, the instructor must determine the type of measurement or evaluation of the student's performance he proposes to utilize. The purpose of this is to identify the difference between the initial behavior and the terminal behavior the student demonstrates during the time of the instructor's influence over him as it relates to the established goals.

THE LESSON PLAN

1. INTRODUCTION
2. DEVELOPMENT
3. SUMMARY

THE LESSON PLAN

In the discussion on "goals" in the activity of teaching, reference was made to employment of an instructor's lesson plan. In any teacher-student relationship a well prepared and rehearsed lesson plan should be an essential basis for the learning experience. Although lesson plans vary in form and content, there are basic elements common to all. These consist of three required segments, namely:

1. Introduction
2. Development
3. Summary

The INTRODUCTION usually contains the following:

1. Motivation
2. Explanation
3. Transition

Obviously the motivator is the "attention-getter" and may or may not be related to the development segment. Since this is the initial impact of the relationship that is to ensue between teacher and student, it becomes of singular significance. Further, once the motivation has been effected, the explanation that follows of "why this is the most important place for the learner to be for the subsequent experience" adds to the student's intrigue and presumably will keep him in the captive state for the required period of time. After this accomplishment, the teacher has but to employ a smooth transition (usually verbal) into the development segment of his plan. Normally, the total introductory time should be approximately three to five minutes for a 30 to 45 minute experience. Audiovisuals are frequently employed particularly as motivators and in the explanation of what is to follow.

The DEVELOPMENT is the guts of the learning adventure. Generally, one does not attempt to develop more than four or five salient points to be learned. These points are usually media oriented depending upon the teaching patterns selected. Too much stress cannot be placed upon the importance of media employment. Since this segment will constitute the highest percentage of time, it is during the development that learner fatigue, apathy or disinterest is most apt to develop. Experiments have proven that after 15 minutes recall begins to sag thus necessitating a change of density of the information bombardment. Thus, the teacher must be constantly alert at this time for student clues as to acceptability. The lesson plan will outline in detail the four or five major points with their minor subdivisions as well as the key points and aid clues. This outline is also accompanied by a time-continuity scale for teacher guidance.

The SUMMARY segment may be designed in several ways. If appropriate, it may be preceded by a question and answer period and/or it may list the conclusions. It should always reinforce the major points of the development segment. The summary may also allude to the expected program for the evaluation of the learn-gain of this experience.

Finally, the summary should prepare the student for future presentations if the learning activity is to be sequential and to have more than one lesson. A desire must be created for future participation.

INSTRUCTOR'S LESSON PLAN

SUBJECT: Workshop on Instructional Strategies on Medical Education	INSTRUCTOR: (If Applicable)
TITLE OF LESSON: Implementation Methods	
TIME PERIOD (TOTAL): 45 minutes	FILE No.:
TYPE OF LESSON: Lecture	COURSE:
PLACE: Holiday Inn, Jacksonville Beach, Florida	No. ASSTS.:

TRAINING AIDS: Movie and slide projectors, flip chart, striptease charts, blackboard, handouts, etc.

OBJECTIVE(S): To identify the implementation methods for medical teaching in continuing education, and to supply helpful hints to assist in such instruction.

INSTRUCTOR REFERENCES: "Preparing Instructional Objectives" by Robert F. Mager and "Handbook of Research on Teaching" N. L. Gage, Editor.

STUDENT REFERENCES AND HOME WORK: Workbook (handout)

TIME	LESSON OUTLINE	KEY POINTS AND AID CUES
0000	INTRODUCTION:	
0130	Read PREFACE - Sea Horse Such is the case when you are assigned the responsibility of instruction.	Preparing Instructional Objectives
0600	Psychodelic film and slides Thought processes as you decide where you're going! Each M.D. here will be faced with the problem soon. We all need help to be better teachers. The purpose of this session on Implementation Methods should provide you with some new insights or will serve as a review on those you already know to assist you in this responsibility. So unless you are already an expert in the field of teaching strategies you'll be interested in the identification of the ways to help you succeed in communicating your intent to others.	Screen movie and slide projector
0800	DEVELOPMENT A. Types of Learning Basically there are three types of learning to wit: 1. Psychomotor - action 2. Affective - attitudinal 3. Cognitive - factual	Flip chart
1100	B. Implementation Methods 1. Pattern Oriented Methods 2. Centered Oriented Methods 3. Categorically Oriented Methods	Striptease charts

TIME	LESSON OUTLINE	KEY POINTS [illegible]
1500	Break for Question	Blackboard
1800	C. Physician Oriented Methods	*Primary Concern
2300	D. The Activity of Learning	
2500	E. The Lesson Plan	Overhead Projector or Handouts
3000	F. The Lecture - Pros and Cons, Tips and Check Sheet	
3500	G. Multiple Choice Questions Importance and Composition 1. The Stem 2. Responses 3. Types of Multiple Choice Items	Handouts and Blackboard
4000	SUMMARY	
	The Addenda in the workbook submitted to each student will outline the Types of Learning, Implementation Methods (with special concern directed toward the Physician Oriented Methods), the Activity of Learning, the Lesson Plan, the Lecture, and the Construction of Multiple Choice Questions--all of which should be most helpful to each of you as you develop plans for your presentations for THEP. Other items for reference are also included for your perusal and assistance.	
	I call your attention to the "Action Cycle for Training Operations" which graphically enumerates some 23 points for a training experience that should be employed.	
	Remember in every teaching experience there should be an appropriate evaluation of the teacher, the student, and the results. Never was this more true than for the teaching experience of practicing physicians for their continuing education. If such evaluation can be patient-oriented, then the optimum evaluation is obtained.	
4500	Just remember the old adage when you think of teaching, "Give a man a fish and he will eat for a meal. Teach him how to fish and he will eat for a lifetime."	Closing Statement

INSTRUCTOR'S LESSON PLAN

SUBJECT:	INSTRUCTOR:
TITLE OF LESSON:	(If Applicable)
TIME PERIOD (TOTAL):	FILE No.:
TYPE OF LESSON:	COURSE:
PLACE:	No. ASSTS.:

TRAINING AIDS:

OBJECTIVE(S):

INSTRUCTOR REFERENCES:

STUDENT REFERENCES AND HOME WORK:

TIME	LESSON OUTLINE	KEY POINTS AND AID CUES

[illegible]

TIME	LESSON OUTLINE	KEY POINTS [illegible]

THE LECTURE

1. RATING SCALE FOR LECTURE
2. TIPS FOR THE LECTURER
3. REPORT ON INSTRUCTION FORM

THE LECTURE

Although the general concensus of teachers confirms the lecture to be a relatively poor method of teaching, nonetheless it still remains the most prevalent. Fortunately, the lecture is usually greatly enhanced by various supplementary means to camouflage the pure form and can be effective for relatively short periods of time, usually not longer than 15 minutes. Studies in England have shown that recall of 41% for the first 15 minutes of a lecture is common, but the percentage drops to 25% after 30 minutes and to 20% after 45 minutes.

The lecture is considered to be more effective to gain attention. What happens subsequent to this positive effect depends solely upon that individual who assumes the role of lecturer. He can only presume the students are listening unless he assures himself that they are by some appropriate means.

However, in spite of all the "cons" against the lecture, it will still, no doubt, be the basic method employed by busy practicing physicians in the presentation of continuing education experiences and thus it behooves us to spend some time to caution you as to the pitfalls as well as to provide you with the standard measuring devices to rate your performance as a lecturer.

INSTRUCTIONAL SKILLS WORKSHOP, 1969

RATING SCALE FOR LECTURE

Respond to each of the following statements by using the coded scale shown below. To indicate your reaction to each statement circle the number which most closely corresponds to your observation.

Coded Scale

5 = Fully
4
3 = Partially
2
1 = Incompletely
0 = Unable to judge

Please do not forget to fill in the name of the person being rated on top of the next page and initials of rater. Check ✓ first session if you are rating a person for the first time; check ✓ second session if you are rating him the second time, etc.

____
Name of person being rated

____
Initials of rater

______ Pre-workshop
______ First presentation
______ Second presentation
______ Third presentation
______ Fourth presentation
______ Fifth presentation
______ Post-Workshop

A. Content

(1-5) Presentation was suited to						
(1) audience level(s) of sophistication	5	4	3	2	1	0
(2) announced objectives	5	4	3	2	1	0
(3) time limits	5	4	3	2	1	0
(4) audience interests	5	4	3	2	1	0
(5) audience needs	5	4	3	2	1	0
(6) Indicated thorough knowledge of the subject.	5	4	3	2	1	0

B. Organization

(7) Specified purpose of lecture in introductory statement.	5	4	3	2	1	0
(8) Organized material in logical sequence.	5	4	3	2	1	0
(9) Used examples to illustrate main ideas.	5	4	3	2	1	0
(10) Presented divergent viewpoints for contrast and comparison.	5	4	3	2	1	0
(11) Indicates own viewpoint.	5	4	3	2	1	0

(12)	Cited authority to support statements.	5	4	3	2	1	0
(13)	Summarized most important points periodically or at end.	5	4	3	2	1	0
(14)	Developed a conclusion related to purposes.	5	4	3	2	1	0
(15)	Established a problem solving set.	5	4	3	2	1	0

C. Delivery

(16)	Displayed sincere interest in subject.	5	4	3	2	1	0
(17)	Appeared at ease.	5	4	3	2	1	0
(18)	Was free of disturbing mannerisms.	5	4	3	2	1	0
(19)	Was sensitive to cues from the audience.	5	4	3	2	1	0
(20)	Encouraged questioning attitude in the course of presentation.	5	4	3	2	1	0
(21)	Avoided inappropriate technical jargon.	5	4	3	2	1	0
(22)	Could be heard by everyone.	5	4	3	2	1	0
(23)	Quality and tone of voice were pleasing.	5	4	3	2	1	0

(24) Tempo of presentation was appropriate to audience.	5	4	3	2	1	0
(25) Humor was used judiciously, appropriately.	5	4	3	2	1	0
(26) Maintained audience interest from beginning to end.	5	4	3	2	1	0
(27) Personality was projected without interfering with purpose.	5	4	3	2	1	0
(28) Personal appearance was pleasing.	5	4	3	2	1	0
(29) Illustrative materials (blackboard, slides, tapes, etc.) were appropriate to content and audience.	5	4	3	2	1	0
(30) Illustrative materials were clear.	5	4	3	2	1	0
(31) Adhered to time limit.	5	4	3	2	1	0

2. TIPS FOR THE LECTURER

a. Plan for some break in the lecture after 15 minutes. a change of pace such as a multiple choice question on the screen.

b. The use of a pretest in the first five minutes is recommended. Be sure the pretest is for learning, not for judgement. Evade the "punishment and reward" concept. The test is not a punishment.

c. Problem solving set in a lecture has been proven to help retain interest such as a clinical problem. Remember the problem should be for the audience, not a stage for the lecturer to perform.

d. Create a setting in which the student wants to know the information the lecturer has to give. And....remember the lecture is providing students with information......to help them learn.

e. Don't lecture as a lecturer. COMMUNICATE. The lecturer must constantly recognize the reaction clues of the audience.

f. Encourage a questioning attitude. Do so by expressing one.

g. Realize the joint expectation of both the speaker...AND THE AUDIENCE. The lecture should not be designed to serve the Faculty's needs but that of the student.

REPORT ON INSTRUCTION

INSTRUCTOR	COURSE	MONITOR
LESSON TITLE		FILE NO.
PLACE	TIME	DATE

RATING ITEM	RATING	
PREPARATION		
Instructor Lesson Plan (Format and Organization)		
Evidence of Thorough Planning and Adequate Rehearsal		
INSTRUCTOR QUALITIES		
Appearance		
Self-Confidence		
Enthusiasm		
Body Vitality		
Contact with Class		
Voice Variety		
Speech		
PRESENTATION		
Introduction		
Logical Development		
Explanation		
Training Aids		
Checked Student Understanding		
Questioning Technique		
Student Participation		
Class Management		
Summary		
CONTINGENT ITEMS		
Demonstration		
Practical Exercise		

(A) SCORE		
(B) NUMBER OF ITEMS RATED		
(C) PRACTICE TEACHING GRADE (A + B)		
(D) EXAMINATION GRADE		
FINAL COURSE GRADE		

MULTIPLE CHOICE QUESTIONS

1. CONSTRUCTION PRINCIPLES
   - a. STEM
   - b. RESPONSES
   - c. TYPES OF MULTIPLE CHOICE ITEMS

Multiple Choice Questions

One of the most time consuming and difficult tasks of an instructor is to compose effective questions to ascertain the student learn-gain as well as the effectiveness of his teaching. Since time of the student (practicing physicians in the case of continuing educational experiences) is paramount, the use of the multiple choice question has gained an enormous popularity. Some consideration, therefore, should certainly be given in this workbook to the basics of good multiple choice questions.

The question is composed of two elements, namely (1) the stem and (2) the responses. In the following table there are eight suggestions each for the composition of these items.

There are a number of types of multiple choices to be utilized in preparing the questions. A variety of types should be designed in any extensive examination program. Ten standard types are listed together with an example of each.

If you follow these suggestions you will greatly enhance the product of your multiple choice questions as well as the totality of your examination.

MULTIPLE CHOICE QUESTIONS

A. THE STEM

1. Contains a clear stated central problem.
2. Stated in question or completion form.
3. Stresses application.
4. Key words underlined.
5. Includes common elements.
6. May include sketches, diagrams, etc.
7. Contains no words which give a clue to the selection or rejection of certain responses.
8. Avoid "nice to know" instead of "need to know" questions.

B. RESPONSES

1. Use four in number (A,B,C,D).
2. Clearly stated and uniform in length.
3. Agree with central problem.
4. Grammatically consistent with the Stem.
5. All related.
6. Only one is best.
7. Arranged in ascending order when numbers are used.
8. Distractors represent common errors and misconceptions.

C. TYPES OF MULTIPLE CHOICE ITEMS

1. Simple fact: What disease causes the most deaths per annum in the United States?

2. Definition: A third degree burn is one which....
3. Purpose: The purpose of the relay in the microphone voltage regulation circuit is to...
4. Cause: If the patient has extreme difficulty in breathing, the possibility of....
5. Effect: Which is most likely to happen if the patient is allergic to penicillin....
6. Recognition of Error: What drug should never be used for the treatment of....
7. Evaluation (Math Problem): What is the amount of the net increase in inventory in the following situation?

a. Closing Inventory	$91,000
b. Purchases	80,000
c. Sales	62,000
d. Opening Inventory	58,000

8. Similarity: Both the timing relay and the control relay require a current imput of....
9. Arrangement: Which of the following tests should be given second priority when diagnosing?
10. Difference: One of the major differences between the A model X-Ray unit and the B model is that the....

ADDENDA

1. Dimensions of Instruction
2. A Challenge of a New Conception of Leadership
3. Types of Evaluation: Chart
4. Follow-up Feedback Questionnaire: Form
5. Conference Evaluation: Form
6. Books for Study and Reference: Bibliography
7. An Action Cycle for Training Operations: Chart

Dimensions of Instruction

The instructional process is enormously complex. There are a number of ways of breaking it down and making it amenable to analysis. We will examine each of these in turn, and relate them to each other as appropriate.

1. Degree of Guidance

A very important dimension of the instructional process is the amount of guidance that the teacher provides for the learner. Instruction may vary from one extreme, where the learner is fully guided through every step of instruction, to the other extreme, where no guidance is provided to the learner.

We may characterize the amount of guidance by examining three aspects of instruction: the problem to be solved, the rule(s) or principle(s) upon which a solution is based, and the specific solution called for. Table 1 characterizes the 8 different patterns and degrees of guidance possible.

Table 1

Problem	Rule	Solution	Instruction Type
Given	Given	Given	Typical Formal Lecture
Given	Given	Not Given	
Given	Not Given	Given	
Given	Not Given	Not Given	Clinical Case Exercise
Not Given	Given	Given	
Not Given	Given	Not Given	
Not Given	Not Given	Given	
Not Given	Not Given	Not Given	Actual Clinical Problem

Can you give examples of some of these categories?

2. Sequence of Instruction

When teaching a set of principles or rules, the instructor can choose between two basic sequences: inductive presentation, wherein he first presents the problems or sample cases to the students and either has them induce the general principles or supplies the appropriate principles himself; and deductive presentation, where the principle is formally presented first, followed by the problems or sample cases to which it is applicable.

It can be seen from Table 2 that the two dimensions, degree of guidance and instructional sequence, are independent of one another.

Table 2

	Maximum Guidance	Minimum Guidance
Inductive		Present patient, ask student to examine, state relevant findings and formulate principles which account for the findings.
Deductive	Bedside Exposition, with principles presented first, followed by exemplary signs and symptoms.	

Can you fill in medical examples for each category?

3. Size of Instructional and Learner Groups

Both the number of learners and the number of instructional sources can vary from one to many. Table 3 describes some possible configurations of these two dimensions.

Table 3

Source of Instruction

		single	several	many
Number of Learners	single	tutorial	multi-media lab	Individualized Curriculum
	several		seminar*	
	many	Lecture		

* Remember! In a seminar, each learner is also a potential teacher. Can you fill in other cells?

4. Direction of Student-Teacher Interaction

Instruction can proceed through communication primarily from teacher to student, from student to student, from teacher to teacher or from student to teacher. The latter occurs when the teacher poses a problem which the student must solve through questioning the teacher. Clearly these communication patterns can take place under different conditions of guidance, instructional sequence and group or instructional source size. The direction of interaction can, of course, change many times within the same session.

5. Approximation to Application Setting

The application setting is the specific context in which the learner will ultimately have to apply what he has learned during instruction. The application setting may be similar to the instructional setting (1) in the characteristics of the situations encountered by the learner, but not in the behaviors he is called upon to perform; (2) in the behaviors he is called upon to perform, but not in the characteristics of the situation, (3) in both the characteristics of the situation and the behaviors to be performed, and (4) in neither of these aspects.

Table 4

		Situation	
		Similar	Dissimilar
PERFORMANCE	Similar	Bedside Supervision	Simulated Clinical Exercise
	Dissimilar	Ground Rounds (as observer)	Formal Lecture or Free Luncheon Consultation

6. Types of Teacher Influence on Students

Teachers may influence students along a dimension from shaping student behavior to modelling behavior for the students to imitate and identify with. In the shaping situation, the desired student behaviors are directly prescribed by the instructor, who monitors the actual performance of the student to insure that performance is appropriate. In the modelling situation, the desired student behaviors are displayed by the teacher, while the student is called upon to imitate these appropriately. In the learning of the intellectual skills and underlying principles of medical diagnosis, modelling predominates. In the teaching of a skill such as percussion, a combination of shaping and modelling will generally be used.

An example of the usefulness of modelling is in the teaching of attitudes which foster continuity of care. To show residents a model in which a physician comes to supervise a clinic once every three weeks is of questionable value in demonstrating the importance of continuity of care.

7. Overall Sequence and Timing of Instruction

A curriculum includes a program of instruction in which degree of guidance, instructional sequence, learner and instructor group sizes, direction of student-teacher interaction and degree of approximation to the application setting are optimally blended, timed and ordered to fit the instructional objectives and the entering characteristics of the learners best. Given (1) a specification of objectives, (2) a description of the relevant entering characteristics of learners and (3) a reasonable task analysis of the sequence of prerequisite capabilities necessary for these learners to achieve the specific objectives in question, the problem of fitting instructional tactics into an overall design and strategy should not be prohibitively difficult.

THE CHALLENGE OF A NEW CONCEPTION OF
LEADERSHIP

By Thomas Gordon
Assistant Professor of Psychology
University of Chicago

A new Conception of Leadership

A small number of social scientists have been cautiously trying out some radically new leadership methods, principally in small discussion groups, in schools, in churches, and in industry. Historically, these new methods are perhaps related to four earlier developments in the social sciences: (1) progressive education with its emphasis upon the fostering of self-responsible and creative students; (2) the movement within industry, which emphasizes the importance of human relations in personnel management, a trend set in motion by the pioneering studies of such men as Elton Mayo, Chester Barnard, F.J. Roethlisberger, Douglas McGregor, and others; (3) the movement stressing the experimental approach to the study of different types of leadership and their effect upon the dynamics of group functioning, represented by such men as Kurt Lewin, Ronald Lippitt, J.R.P. French, Jr., and others; and (4) the development of new methods in the psychotherapeutic treatment of the individuals and groups, particularly the distinctive and controversial approach of the non-directive or client-centered therapists, under the leadership of Carl Rogers, and the modified psychoanalytic approach used by the Tavistock Clinic in doing social therapy with groups and organizations in England.

In this article, I shall describe a type of leadership that is based upon learnings derived from these earlier developments and upon learnings from my own recent experiences. The leadership approach that has evolved out of these experiences I have called "group-centered" leadership, simply to differentiate it from other approaches considered more "leader-centered."

The Attitudes of the Group-Centered Leader

One of the most outstanding characteristics of this group-centered approach to leadership is that it seems to be based upon a belief that the individual is more important than the group.

To the group-centered leader, a group exists for carrying out the purposes of its members; the group is simply the means by which the members are enhanced through the achievement of their purposes. It is thus incompatible with his values that a group exists for the purpose of carrying out only the goals of the leader. Thus, the group-centered leader as a teacher sees his first task as one of helping his group of students to define their own goals. He believes that this should be the responsibility of the total group, consisting of the students and himself, and thus is unwilling to set the goals for the group.

Contrast this approach with the traditional one. Ordinarily, the teacher tells the group what material they must learn, what books they should read, and when they must be read. He decides when he will lecture to the group and determines what will go into these lectures. He decides how much the students should learn and constructs examinations to measure how successfully they have achieved this goal. In short, it is the commonly accepted practice in education for the teacher to set the goals for the group and to determine the means by which these goals will be reached. The students are thus denied the right to have a voice in deciding their own destinies. The group does not exist for its members, but for accomplishing the goals of the leader--a leader who, in fact, is seldom even chosen by the group. In education, we have defended this undemocratic practice by saying that students are not capable of selecting their educational objectives and that only teachers and administrators know what is best for the student.

A second basic attitude of the group-centered leader is that a group will be maximally effective when it utilizes the creative potential of every member of that group. In more practical terms, this is a belief that a group faced with a problem will arrive at the best solution to that problem if all the ideas, skills, and knowledge of its members are available for use by the group. Quite apart from the proven fact that group members will better accept decisions they have helped make, it is believed by the group-centered leader that decisions to which group members have contributed will, in the long run, be better decisions than those which are made for the group by its leader alone.

I have stressed these basic attitudes of the group-centered leader because they are the foundation of his behavior as a leader. People can only act in ways that are consistent with their deep-seated attitudes and beliefs. This is why I have so little faith in present day leadership training programs. Most of them are technique-oriented and are based upon the faulty assumption that you can teach democratic leadership or human relations skills in the same way you teach history or how to operate a drill press. Changing one's methods of relating to people or one's habits of leading groups requires fundamental changes in feelings, attitudes, and beliefs. These do not change by reading books, studying manuals, or listening to lectures on how to become a better leader. Let me summarize, then, by briefly reviewing some of these basic attitudes and beliefs of the group-centered leader:

1. The goals of a group should be the goals of the individuals who comprise the group, because in the long run group-determined goals will be more beneficial to the total group than leader-determined goals.

2. Group members must be given the rightto have a voice in deciding matters which will affect them.

3. Before leaders will give this right to groups, they must have faith in the capacity of groups to make correct decisions.

4. To have faith in the capacity of a group, a leader must trust people and respect the capacities of the individual.

5. Participation is not simply a device to get people to accept decisions, but it pays off in terms of better decisions, better productivity, and higher morale.

6. If the total group has access to the resources of all its members including the designated leader, it will make wiser decisions than those made by the leader alone.

The Role of the Group-Centered Leader

Although it is extremely difficult to describe adequately in words such a complex and dynamic thing as a group-leader's role, nevertheless it is in the group-centered leader's behavior that we can see most clearly some of the distinctive characteristics of this leadership approach. The role of this type of leader must be described in terms of both what he is trying to do and how he actually implements his goals.

Creating an Accepting Atmosphere

What is it that a group-centered leader is trying to do? How does he define his task? First, it seems that as a leader he tries to make every member feel free enough and secure enough to give to the group his maximum contribution, whether it be an idea, a skill, a criticism, an opinion, or a personal feeling. Or it can be stated in a somewhat different way--that the leader tries to remove all of the psychological barriers that tend to block group members from actively participating in a group to their full potential. These barriers are many, and our research and experience have shown that they exist in almost all groups. Let us examine some of these obstacles to full group participation.

First, we know that people are not free to contribute creatively when they feel a deep lack of worth as a person. Individuals who have been made to feel generally less worthy than others are legion.

Another barrier to spontaneous and creative participation in a group is the feeling that one's contributions will be negatively evaluated, misunderstood, ridiculed, or rejected by other members and especially by the group leader. It is almost a truism that people will not give of themselves or make significant contributions to a group if they feel under attack. Under such conditions, group members dissipate their energies trying to figure out what will be acceptable to others, and the net result is that their potentially creative contributions become watered down and stereotyped as the person strives to conform. Nowhere is this more apparent than in education. By the time a student has reached the end of high school, he has become thoroughly conditioned against expressing a novel idea or making a creative interpretation of what he perceives, largely because his earlier attempts have been met with subtle devaluation or outright ridicule. It is my opinion that, as educators, we have failed to reward individuality by promulgating a system in which the student's creative contributions are not genuinely accepted, so that he learns that it is less profitable to think for himself than it is to learn to think the way that the scholars living before him thought, or the way that the teacher standing before him now thinks.

Being sensitive to the existence of these two barriers to group participation--namely, the members' feeling a lack of worth and feeling the threat of having their contributions rejected or devaluated, the group-centered leader tries to create a non-evaluative, accepting, and safe atmosphere in the group. How does he do this?

He avoids making evaluations of the members' contributions--either positive or negative evaluations. He tries to see each contribution as something worthy of his undivided attention and deserving to be understood. For him, there are no irrelevant contributions, for each contribution has some relevance to the member making it, and the leader tries to understand this relevance. This ability to receive all contributions without evaluating them is best described as "acceptance." The group-centered leader responds as if to say, "I am listening to what you have to say, I understand it, and I accept it as your contribution." Strangely enough, this kind of accepting response is extremely rare in our culture. Each one of us can prove how rare such non-evaluative responses are by listening carefully to the responses that are made by two people discussing some important issue. You will find that people invariably respond to others with statements that imply either agreement or disagreement, either a positive or a negative evaluation. Genuine acceptance, however, implies neither; it merely indicates understanding and the absence of a desire to change the other person.

An examination of transcripts of group sessions that have been electrically recorded reveals that traditional group leaders usually respond to group members with such statements as:

"That is a good idea."
"I disagree with that."
"That doesn't make sense to me."
"I see it differently."
"I think you're right."
"You shouldn't say such things."
"Now, don't feel that way."
"You don't have enough experience yet."

The group-centered leader's responses, on the other hand, are more likely to be:

"I see what you mean."
"This is what you believe from your experience."
"You are saying such and such."
"Let me see if I understand you correctly."
"I follow you."
"This is what you are trying to say..."

Experience has shown that such accepting and non-evaluating responses on the part of the group leader, if backed by genuine accepting attitudes, have an immediate effect in making group members feel that their contributions are welcome, that they have worth as persons, that it is safe to express how they feel, that their membership in a group really counts. Only when people feel this way can they become active, creative, productive members of a group.

Distributing Leadership Throughout the Group

There is yet another barrier that must be broken down if a group is to become maximally effective. Stated in one way, the leader must actually lose his leadership. It seems that the very presence of an authority-figure, an expert or a formal leader in a group, is a real barrier to free participation of group members. In industry, in religious organizations, in government or education, most groups do have a formal leader, and the members have learned to depend upon this leader to carry out a disproportionate number of the functions required by the total group. Somehow in our culture, there has developed the notion that one member of a group is the leader and the rest are the followers, one member is endowed with superior qualities that enable him to make better decisions for a group than the group itself. Perhaps this notion begins when the child is in the family group where he quickly learns that father (or mother) is his superior; he is the head of the family who is always right and who must at all times be obeyed. This idea is later reinforced when the child goes to school and discovers that his teachers call the shots. They too somehow have been given the right to demand obedience, for the teacher always knows more than the student.

From these early experiences, which are followed by many others, the child learns that the world consists of the strong and the weak, the leader and the followers, the teacher and the learners, the minister and the flock, management and the worker. Along with these notions, he also develops some consistent ways of reacting to leaders. Either he tends to become dependent upon them and submits apathetically to their authority, or he reacts against their authority with hostility and aggression. In either case, he is lost to the group as a productive member.

It is because people are not completely free to be themselves in the presence of authorities or experts that we are led to the conclusion that the first task of a group leader is to lose his status or authority. He must somehow act so that group members see him more and more as just another contributing member of the group. If he can accomplish this, then the group members no longer need to submit to him or fight him.

How does a group leader lose his status and authority; how does he distribute leadership throughout the group? First, he has to be willing to give us most of the functions that traditionally re thought to go with group leadership---calling meetings to [illegible], preparing agendas, deciding who is to speak, keeping order, encouraging shy members and suppressing aggressive ones, keeping the discussion on the topic, and so on. For him to give up such functions may seem strange, because group members almost invariably look to a leader to perform these functions for them. Yet, it is this very dependence of the group members upon their leader that seems to inhibit spontaneous and creative participation within the group.

Secondly, the group leader must be willing to allow the group to take over as much of his authority as is possible within the limits of the situation in which he is operating. This may mean turning over to the group the power to hire and fire, to evaluate and promote, to make decisions that will affect others in the group, to decide upon long-range objectives, and so on. By relinquishing his authority to the group, the leader conveys to the group that authority should rest with the total group, not with any single member; that he is confident in the group's ability to assume responsibility, and that he trusts the group's judgement in exercising its authority.

Perhaps some of the meaning of this kind of behavior on the part of leaders can be conveyed by an example which should be of particular interest to those in the field of education. Recently a group of us attempted to conduct a summer workshop for education leaders following group-centered principles of leadership. The delegates who enrolled for this three-week program came from all parts of the country and were people who were in leadership positions in their professional community. They came to learn better methods of leading groups. Five of us began to plan several months in advance how to run the workshop. First, we began by addressing ourselves to such questions as:

What do we want thedelegates to learn?
What are our goals for them?
How will we organize the group?
Shall we keep the total group together or break them down into sub-groups?
What materials should we have them read?
How will we evaluate how much they learn?

Here we were, a group of leaders, starting out our planning in a way that is usually expected of an efficient staff group--defining our goals, planning methods of achieving them and ways of evaluating how successfully the goals were reached. This is the usual approach recommended for curriculum planners or for conference planners. Soon, however, we began to ask ourselves some embarrassing and challenging questions:

Why are we planning for them?
Do we really know what the delegates will need?
Are we trying to satisfy our own needs to change others and to act the role of the expert?
Do we really have ready-made answers to problems they will bring?
Why don't we trust the group enough to let them plan their workshop?

After a considerable number of weeks spent in tackling these questions we arrived at what we felt was a dangerous yet exciting and challenging plan. We decided to try to leave all of the planning up to the delegates once they arrived. We would put this group-centered idea to a real test, to determine whether a relatively large group of total strangers could come together and assume responsibility for formulating their own goals and for organizing their group life so as to reach those goals. In a sense, each of us was gambling on whether the group could do this for itself or whether we as their leaders had to do it for them.

Having decided to risk it, we then began to express our doubts and our own insecurities. These expressions took many different forms:

Won't they resent our not having a program laid out for them--could we accept their resentment and hostility towards us?
Won't they flounder around for weeks and learn nothing?
Don't we have a moral obligation to teach them what we know--won't they expect us to do this?
What if they decide not to read anything?
If we don't plan to give lectures or lead discussions, won't they think we don't know anything?

These represent a small sample of the many fears we had. Somehow we worked through them and put our trust in the group.

The delegates arrived at the first meeting with their notebooks and pens and with expectations that they were going to be given the latest scientific dope about techniques of group leadership. They were in for a rude shock. One of the staff opened with this statement: "Well, here we are for our first meeting together. A few things have already been planned for you and to a certain extent some responsibility has been taken away from you as a group. Yet we as a staff had to plan for your living quarters, arrange where you could eat, and decide on three weeks as the length of the workshop. We also felt we had to plan ahead in order to collect some resources for you, so we have built up a library for your use. Other than these few things, we have done no planning, for it was our hope that from here on the total group would take over the responsibility for organizing its life during the workshop."

Then this staff member ended his introduction abruptly at this point. As you might expect, there was an ensuing pause--an embarrassingly long one for the delegates. Finally, one delegate made a suggestion that the leaders begin by defining some terms. The leaders responded in such a way as to indicate that they understood the meaning of this suggestion, but they added nothing that would convey agreement or disagreement with the suggestion. This puzzled the group, to say the least. Another member finally made a suggestion, and again the same kind of response from the leader. A third member, then a fourth and fifth made contributions. From time to time, a delegate would appeal to the leaders for their expert opinion as to what other workshops had started out with. Often another delegate would challenge the idea that we should copy some other group. So it went for an hour. Here was a group tackling its first problem, how to reach a decision, and they were finding it a tough problem. At the end of two hours, the group made a decision--one small decision. They decided to introduce themselves to the total group and tell why they came to the workshop. This led to a second decision, which was to meet at nine o'clock the next morning to assess their own needs so they could have a better basis for planning.

The group met the next morning and again that afternoon and evening. By the end of the evening they had worked out a program for the first week. They had made many decisions by this time, regarding such things as length of meetings, the proportion of time to be spent in the total group and in sub-groups, who would be in each sub-group, what should go on the agenda for the next few total group sessions, etc. Within three days this collection of individuals had become a self-responsible, productive, self-determining group. At the end of the three days, one of the staff put it this way: "This group has become so self-responsible and independent that should one of us on the staff actually try to take over and run the group, he would be tossed out on his ear."

That remark carried a host of meanings for me. It meant that in a relatively short period of time, we as leaders by radically changing our leadership role had created a democratic group that was strong enough to withstand an attempt to domination by an authoritarian leader. It also meant to me that what we did as leaders, while it appeared to be anything but leader-like, was actually to provide this group with a kind of leadership that would otherwise have remained submerged and unavailable to the group.

To bring a close to a long story, the group went on to tackle more difficult problems. They learned about leadership, but it was in leaderless discussion groups and through voluntary reading. Most of their learnings, however, came from this strange and wonderful experience of learning how to become a democratic group in which each member could take on leadership functions by being made to feel free from dependence upon a single leader.

TYPES OF EVALUATION

I. Paper and Pencil Tests

  A. Fixed Response
    1. True-false
    2. Multiple choice
      a. One correct response
      b. Variable number of correct responses
    3. Classification
    4. Matching

  B. Free Response
    1. Essay
    2. Short answer
    3. Completion

  C. Programmed Sequence

II. Oral Tests

  A. Structured

  B. Unstructured

III. Performance Tests

  A. Structured
    1. Programmed patient
    2. Technical Skill

  B. Unstructured
    1. Patient workup
    2. Research project

IV. Unobtrusive evaluation

WORKSHEET FOR DEVELOPING OBJECTIVES

	DOMAIN		
	Cognitive	Skill	Affective
ABSTRACT			
SPECIFIC -Non-Performance			
SPECIFIC -Performance			
CONDITIONS			
CRITERIA			

INSTRUCTIONAL SKILLS WORKSHOP, 1969

Follow-up Feedback Questionnaire

____
Please sign your name here (optional)

1. Did the Workshop satisfy your expectations?

_____Yes
_____No
_____In Part

If No, continue to question 2
If Yes, or In Part, describe how:

2. In what ways did the Workshop fail to meet your expectations?

3. Which skills did you learn or improve upon during the Workshop?

4. Was adequate opportunity provided to practice the desired skills?

_____Adequate
_____More practice would have been helpful
_____Less practice would have been sufficient

5. Which particular learning situation was most helpful to you? (Please be specific)

6. Which particular learning situation was least helpful to you? (Please be specific)

7. To what extent was there adequate feedback to improve your skills?

_____Adequate
_____More would have been helpful
_____Less would have been sufficient

8. What did you learn about yourself from the feedback?

9. To what extent did the program provide you with the opportunity to accomplish your unique, individual goals?

_____Completely
_____Partially
_____Not at all

CONFERENCE EVALUATION

STUDENT INSTRUCTOR	STUDENT OBSERVER
LESSON TITLE	DATE

Observers will give careful analysis to the following items. Remarks and suggestions should be specific. Such comments as "good", "poor", or "excellent" are insufficient for analysis purposes.

ITEM	ANALYSIS
APPEARANCE AND SELF-CONFIDENCE	
ENTHUSIASM AND BODY VITALITY	
CONTACT WITH CLASS	
VOICE VARIETY AND SPEECH	
INTRODUCTION	
LOGICAL DEVELOPMENT	
EXPLANATIONS	
TRAINING AIDS	
CHECKED STUDENT UNDERSTANDING	
SUMMARY	
CLASS MANAGEMENT	
QUESTIONING TECHNIQUE Build-Up Thought Provoking Ask, Pause, and Call Follow-Up	
STUDENT PARTICIPATION Distribution of Responses Balance/Instructor-Class	

USAES Form 41
Rev 15 Nov 57

-24,174—ARMY—FORT BELVOIR, VA.

: Teacher Training Program Participants

RE: Books for Study and Reference

Listed below are books which you may find helpful for study and reference during the next six weeks. Many of the books listed may be found in our CSME Library - Room 818. However, in most cases, our collection contains only one copy of any one item or book; thus, for additional copies you will have to go to the main Medical Center Library, the Library of Medical Sciences, located on the first floor of the College of Medicine Building, Room 119 - DMP.

When checking books out of the Library of Medical Sciences use your green Building Pass as a means of identification.

1. Teaching and Learning in Medical School, George E. Miller (Ed.), Harvard University Press, 1961.
2. The Dynamics of Learning, Nathaniel Cantor. Henry Stewart, Inc., 1961.
3. Educating Tomorrow's Doctors, Milton J. Horowitz, Appleton-Century-Crofts, 1964.
4. Encyclopedia of Educational Research, Chester Harris, (Ed.), MacMillan, New York (3rd Ed.), 1960.
5. Handbook of Research on Teaching, N. L. Gage, (Ed.), Rand McNally, Chicago, 1963.
6. The American College, Nevitt Sanford, (Ed.), John Wiley & Sons, N. Y., 1962.
7. Mental Measurements Yearbook, Oscar Buros, (Ed), Gryphon Press, Highland Park, N. J. (6th edition, 1965).
8. Taxonomy of Educational Objectives: Handbook I: Cognitive Domain, Bloom, Benjamin S., (Ed.), N. Y. Longmans, Green & Co., 1956.

9. Constructing Evaluation Instruments, Furst, Edward J., N. Y. Longmans, Green & Co., 1958.

10. Educational Measurement, Lindquist (Ed.), Washington: American Council on Education, 1951.

11. Educational Measurement and Evaluation, Remmers, H. H. & Gage, N. L., N. Y., Harpers, 1955. 1965

12. Creativity and Intelligence, Getzels, J. W. and Jackson, P. W. New York, John Wiley & Sons, 1962.

13. Essentials of Psychological Testing, Cronback, Lee J., N. Y. Harper Bros. 1960.

14. Theory of Mental Tests, Gulliksen, Harold, John Wiley & Sons, 1950.

15. An Introduction to Educational Research, Travers, Robert M. W., N. Y. MacMillan, 1958. 1964

16. The Art of Teaching, Gilbert Highet, Vintage Books. 1950.

17. The Dynamics of Learning, Nathaniel Cantor, Henry Stewart, Inc., 1956.

18. For Future Doctors, Alan Gregg, University of Chicago Press, 1957

19. The Aims of Education, Alfred North Whitehead, Mentor Books. 1929.

20. Preparation for Medical Education in the Liberal Arts College, (both the initial study and the restudy), Aura Severinghaus et al, McGraw-Hill.

21. Basic Principles of Curriculum and Instruction, Ralph W. Tyler, University of Chicago Press.

22. The Process of Education, Jerome S. Bruner, Harvard University Press, 1960.

23. Teaching Tips, Wilbert McKeachie, George Wahr Publishing Co., Ann Arbor, 1960.

24. Boys in White, Becker et al., University of Chicago Press, 1961.

25. The Learner in Education for the Professions, Charlotte Towle, University of Chicago Press, 1954.

26. Teacher in America, Jacques Barzun, Little, Brown & Co., 1945

27. Excellence, John Gardner, Harper Bros., 1961.

28. The Student Physician, Merton, Reader, et. al. 1957

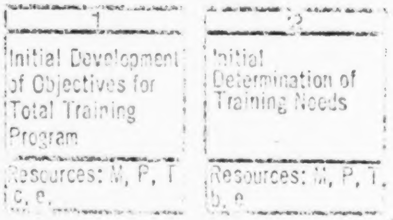
29. House of Intellect, Jacques Barzun.

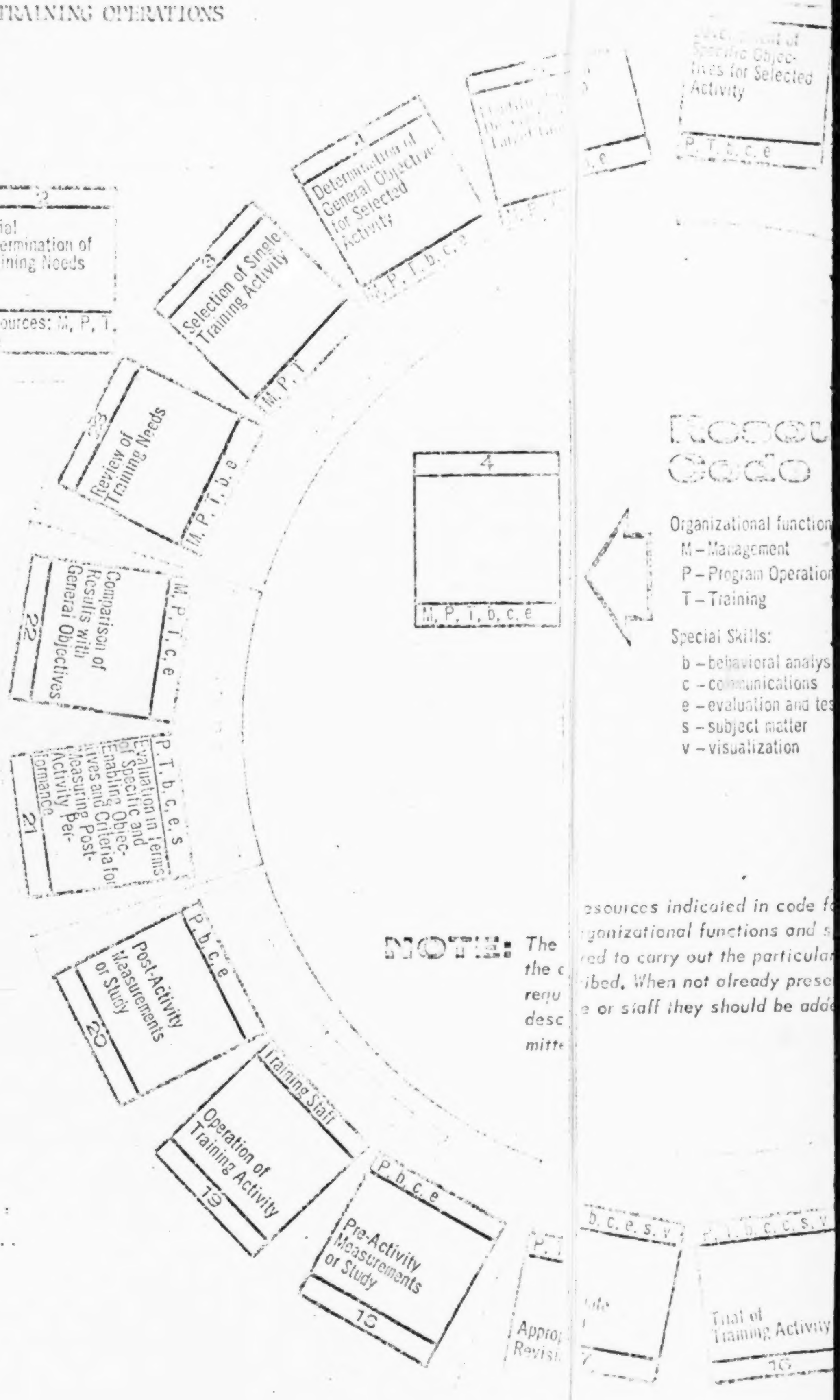
30. Human Behavior, Berelson and Steiner.

31. Working with Groups, Lifton. 1961

32. Learning to Work with Groups, Miles 1959

AN ACTION CYCLE FOR TRAINING OPERATIONS

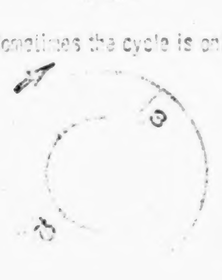

1
Initial Development of Objectives for Total Training Program
Resources: M, P, T, c, e.
2
Initial Determination of Training Needs
Resources: M, P, T, b, e


3
Selection of Single Training Activity
M, P, T
Determination of General Objectives for Selected Activity
M, P, T, b, c, e
b, e
M, P
Specific Objectives for Selected Activity
P, T, b, c, e
4
M, P, T, b, c, e
Resource Code
Organizational function
M – Management
P – Program Operation
T – Training
Special Skills:
b – behavioral analys
c – communications
e – evaluation and tes
s – subject matter
v – visualization
23
Review of Training Needs
M, P, T, b, e
22
Comparison of Results with General Objectives
M, P, T, c, e
21
Evaluation in Terms of Specific and Enabling Objectives and Criteria for Measuring Post-Activity Performance
P, T, b, c, e, s
20
Post-Activity Measurements or Study
P, b, c, e
19
Operation of Training Activity
Training Staff
18
Pre-Activity Measurements or Study
P, b, c, e
P, T
Approp Revisi
b, c, e, s, v
17
P, T, b, c, e, s, v
Trial of Training Activity
16

NOTE: The esources indicated in code fo
the c rganizational functions and s
requ red to carry out the particular
desc ibed. When not already prese
mitte e or staff they should be adde

All too frequent cycle . . .

Sometimes the cycle is only . . .



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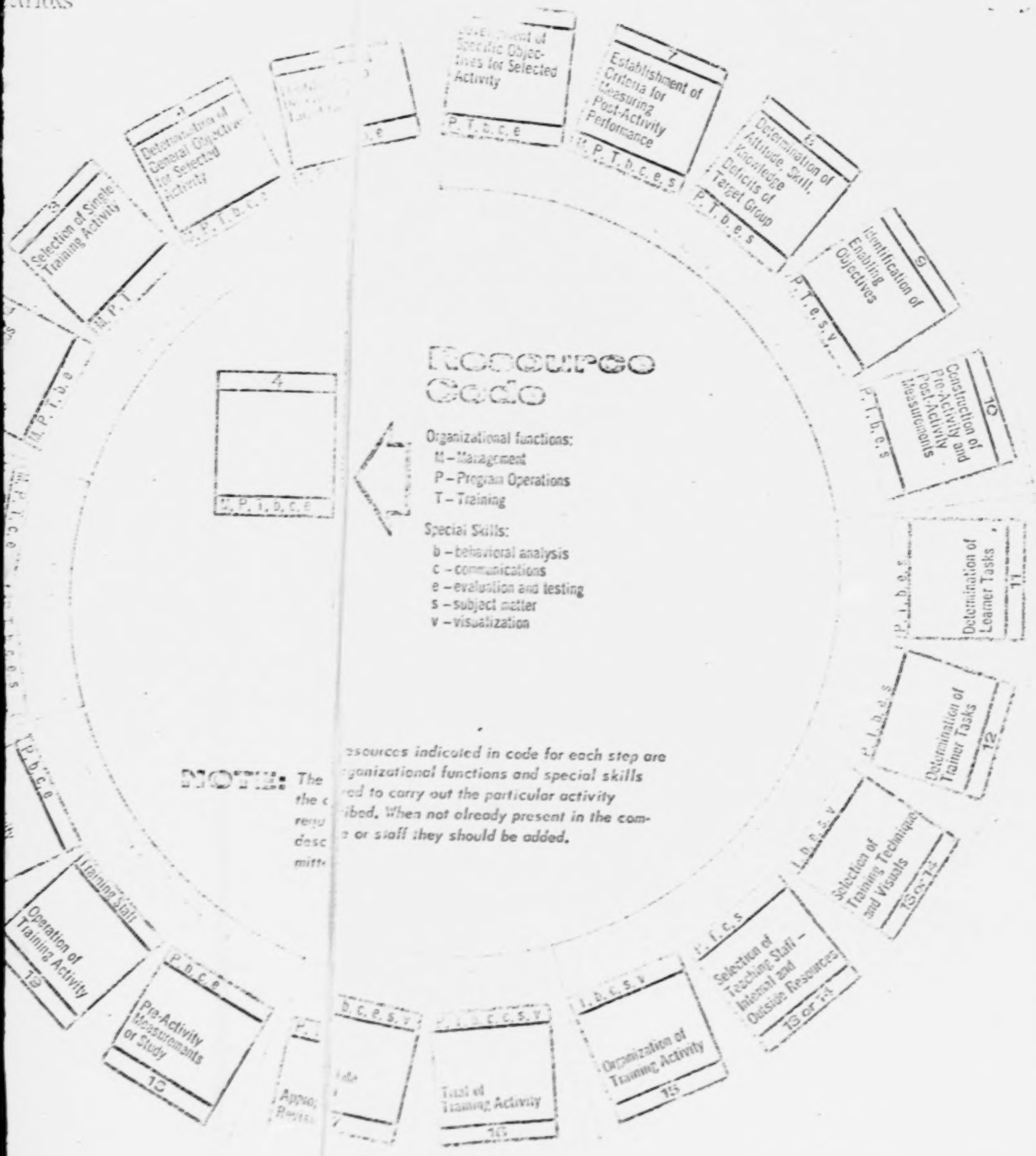

3
Selection of Single Training Activity
M, P, T
4
Determination of General Objective for Selected Activity
M, P, T, b, c, e
b, e
Development of Specific Objectives for Selected Activity
P, T, b, c, e
7
Establishment of Criteria for Measuring Post-Activity Performance
M, P, T, b, c, e, s
8
Determination of Attitude, Skill, Knowledge Deficits of Target Group
P, T, b, e, s
9
Identification of Enabling Objectives
P, T, e, s, v
10
Construction of Pre-Activity and Post-Activity Measurements
P, T, b, e, s
11
Determination of Learner Tasks
P, T, b, e, s
12
Determination of Trainer Tasks
P, T, b, e, s
Selection of Training Techniques and Visuals
13 or 14
T, b, c, s, v
Selection of Teaching Staff – Internal and Outside Resources
13 or 14
P, T, c, s
Organization of Training Activity
15
T, b, c, s, v
Trial of Training Activity
16
P, T, b, c, e, s, v
b, c, e, s, v
P, T
Approv
Revis
17
Pre-Activity Measurements or Study
18
P, b, c, e
Operation of Training Activity
19
Training Staff
M, P, T, b, e
M, P, T, c, e
T, P, b, c, e
4
M, P, T, b, c, e

Resource Code

Organizational functions:

- M – Management
- P – Program Operations
- T – Training

Special Skills:

- b – behavioral analysis
- c – communications
- e – evaluation and testing
- s – subject matter
- v – visualization

NOTE: *The esources indicated in code for each step are*
the c gonizational functions and special skills
requ red to carry out the particular activity
desc ibed. When not already present in the com-
mitt e or staff they should be added.

JACKSONVILLE HOSPITALS EDUCATIONAL PROGRAM

EVALUATION OF BHM CONFERENCE ON INSTRUCTIONAL STRATAGIES

1 – Agree
2 – Uncertain
3 – Disagree

Please check the appropriate spaces.

	1	2	3
This was a good introduction to principles of education.	14	4	12
This will have no effect on conferences for which I am responsible.	2	4	12
We must continue to look to the "experts" for our programs.	5	4	8
Continuing education is best given at ones homebase.	14	4	0
This conference satisfied the ego of all participants.	3	14	1
A major deficit in our local continuing education programs is lack of planning.	14	3	2
Additional seminars on specific teaching techniques but with smaller groups are desirable.	7	7	4
This conference has provided me with a greater understanding of the application of pedagogic principles to our continuing education programs.	15	3	1

Rank in order your ideas as to the contribution of each of the following to continuing education.

Staff Conferences
Grand Rounds
Lectures (local)
Lectures (Guests)

Seminars
Post Graduate Courses
Review of Cases
Others (specify)

Staff Conferences, Grand Rounds, Lectures (Guests), Seminars, Post Graduate Courses and Review of Cases all ranked nearly identical as to priority of educational merit.

Other comments are welcome:

EXCERPTS OF THE PROCEEDINGS OF THE FULL FACULTY MEETING TO EVALUATE PROGRESS AND DISCUSS IMPLEMENTATIONS

Attending were approximately eighty members of the faculty plus Mr. Norman Tucker; Dean Emanuel Suter and Dr. Paul Elliot of the University of Florida, College of Medicine; and staff.

Dr. Max Michael:

On a contract basis for the past two and a half years, we were to develop a volunteer faculty principally in the area of continuing education in his community. Mr. Norman Tucker was our contract officer.

The question of developing a faculty in Jacksonville was under discussion several years ago and in particular started even before we developed the affiliation agreement with the College of Medicine and the J. Hillis Miller Health Center. There were many thoughts as to how this would come about and what the purpose of a faculty would be. Indeed, most importantly, was the question of how it would be chosen. At the meeting with the executive faculty in Gainesville, three or four years ago, the discussion came up at that time of how many people are going to be on the faculty, how it will be chosen, and indeed, what will be their responsibilities. Well, at that time, we just pulled a figure out of the air and estimated 40 maybe 30. The question was, on what basis would they be chosen. The general feeling was the selection would be on the basis of contribution of teaching in Jacksonville. There would be no firm commitment at the time in Gainesville. The teaching program would be here in Jacksonville for not only housestaff, but also in the area of continuing education and hopefully, one of these days when students come over, teaching the students. We'll go more into that at a later date.

Under this Bureau of Health Manpower Contract, we've had several seminars and workshops which some of you have been involved in. One was on the general principle of the educational process; we had one on audio-visual materials; another on the development of conferences, and so on. Our original ideas have changed somewhat under the contract, and we now are in the process of teaching some of our ideas, as one should do when one progresses.

The criteria for faculty membership was for contributions in teaching, quality of teaching (which I can assure you is a very difficult thing to evaluate), and involvement in the community educational process. Contained in this little folder that you have is some information on how faculty appointments are made.

The question of rank comes up often. Does one start off as a Clinical Instructor; does one start off as a Clinical Professor, or what? This is a very difficult thing to specify. Some departments are going to be handled in one way and some in another. But I emphasize to you that all appointments are subject to renewal annually. There is no lifetime appointment.

Each appointment is on an annual basis, and again, the criteria for evaluation for [illegible] depend upon the teaching abilities and time and effort spent in teaching activites. Promotions will be made. Promotions have to be recommended to the College by the Executive Committee of each individual department through the Department Chairman in Gainesville.

There are two types of faculty appointments; there is the full academic type, and there is the volunteer, or clinical, appointment. The academic appointments are given to selected full-time people in the community. There has been a change in the modes of full-time academic appointments and last week the Board of Regents approved a new type.

I know you've all heard of how monies had to be sent to Gainesville and then came back. This was done because the rules of the Senate of the University stated that a full faculty appointment to accrue tenure, a person must receive at least 51% of their salary from the State. Yes, this transfer applies. The new arrangement is of a type with affiliated services - affiliated institutions, or associations. Our full-time faculty will have a full appointment without the word clinical in front of it, but do not assume tenure. They do not have to receive 51% of their salary from Gainesville.

There are fears that in becoming a part of the University, the University will take over and tell everybody what to do, how to practice medicine, how much money to make and how to run the hospitals. Another fear is that the full-time faculty will "squeeze out" the volunteer men. Well, these are natural apprehensions, and we want to talk some of these problems - the fear that the full-time faculty will dictate practice, take patients, and so on. I think that these are things we must face up to. If one has these feelings, what does he do: what is his recourse?

He has the department chairman in Jacksonville. If he feels he still is not being heard properly and that his gripe is not being answered, or his suggestions are not being followed, then he's got the JHEP Executive Committee.

In the package distributed to you there's a copy of the original Document of Affiliation that was approved by the Regents in September, 1969. Therein are described the mechanics of how appointments are made. There are outlines of the various Department Chairmen; what they are, who the Associate Chairmen are; the make-up of the Assistant Dean's Advisory Committee and the make-up of Dean Suter's JHEP Advisory Committee.

Now what of the future activities of the faculty and in what direction are we going? One of the things that I plan to do before this session is over is appoint a small committee to give some considerations to what type of organizational structure you want, or, if you do want an organizational structure. Do you want to work with committees; do you want to work with the body as a whole; how will this interdigitate with the State and County Medical Society and individual hospitals? How you will relate to the College of Medicine? All these things must be considered. We intend to strengthen this faculty organization. We want to develop new programs and have some control over the type of programs that we develop. Most importantly, we want to prepare ourselves for the students that will soon be coming. There will be students coming from Gainesville, perhaps later on from Tallahassee. (Dr. Elliot, who will be the Director of the program in Tallahassee, is going to discuss some of that with us later). We want to involve this faculty more in continuing education. New, imaginative things must be tried out and tested in order to come up with something to help us.

comment was made to me recently by one of the internists who attended a [illegible] "Topics in Medicine". He pointed out how stimulating it was and said, "You know we've got a lot of talent here in town that could do an awful lot of teaching, if we could work out how to utilize that ability." This is what we must do.

Finally, one of the concerns that I think we all have is why the College of Medicine is interested in having a faculty in this community? What is the faculty supposed to do? How are we to fit into the educational program for students, housestaff and in continuing education? To get those answers I would like to turn the discussion over to Dean Emanuel Suter.

Dean Emanuel Suter:

Thus far I would like to express my pleasure and satisfaction that we do have a group of faculty here that can be identified. But I also noticed that earlier, the first time in preparing for this occassion, that we do not have a catalogue, nor do we have a pamphlet that at least lists all of the faculty together, and maybe that is one of the first things which we have to do tomorrow when this meeting is over. Well, Max has a question and maybe some of you have a question. What are the motives and objectives for the College of Medicine to be involved in the program in Jacksonville and expand a considerable amount of the energy of our faculty in developing such a relationship? I think there are a number of reasons, some of them selfish, and others more generally beneficial to all. I think the larger, more general motives are obvious to all of us as we enter a phase in medical education where the increase in numbers of students is of great importance and predominance in everybody's mind. I think we have to harness every resource that can be brought into the field of medical education. When one looks at Jacksonville and its resources that are potentially available for education, one immediately agrees that there has to be a relationship between the two. Environment like the one offered in Gainesville is quite different from the one offered in a city like Jacksonville. While I think it was a wise decision that the medical school was anchored in the University, it is also important for a medical student to have strong relationships to the varieties of communities in shape, size, economic structure, etc.; and a variety of medical groups, in terms of sophistication, etc.

I call our relationship an association, because I think that it implies from the beginning that each offers something essential to the cooperative venture. What have we accomplished? The first thing of course for the College of Medicine is that it has added a new dimension in which we have to think. It's like coming from a little town of a very provincial country - you suddenly propel yourself into the international scene and you have to think differently. So it has forced us, to our benefit, to think somewhat differently. Secondly, I think that we have established a nucleus of a full-time and part-time volunteer faculty, which I think is remarkable. This has a tremendous potential for further program development. We have established certain procedures, which make sense, and which facilitate the relationship between the two institutions. As we have progressed, we have recognized areas of conflict which are bound to occur. I'm pleased, in a way, that the conflict has come to my attention and has not taken on more serious proportions. I think there are three areas of conflict, or potential conflict. One is internal conflict, within JHEP. The potential conflict between

JHEP and the institutional members of JHEP - the hospitals versus the organization. The second is an internal conflict that may arise within the hospitals, namely those individuals who arrive and are academically oriented (that is, have a program that is balanced between education, research and service) and those whose programs are predominantly service oriented by necessity. There will always be conflict between these aspects in a university or teaching Hospital. The conflicts are generated by strong individuals. There are strong individuals in the practice of medicine and there are strong individuals in the academic sector. The resolution will come as certain attitudes are changed, on all sides. There is a lack of tradition in having an educational program in this community and therefore there have to be certain adjustments. But I still think that so far we have had relatively minor problems, and we are very fortunate.

I think one of the important aspects is that the JHEP Faculty must be mixed faculty. I think half of the justifications for our association with JHEP is indeed, mixed faculty, and it's constant striving to a productive, working relationship between the voluntary and the full time faculty. I think we have much to do in this area for both sides. We have to think about new educational techniques which allow the practicing physician to make a direct contribution to education.

There is also conflict possible between JHEP and University of Florida. I think that is worthwhile to mention that for several years I have traveled rather frequently between Gainesville and Jacksonville. In the beginning, the response was usually negative; namely, what do they want; what do they want to do with us; and get from us. Until one day a meeting erupted and the question on everyone's mind was finally asked: what are you going to do for us? When are you finally going to do something for us? I think this was a turning point of our beginning negotiations. From then on, some of the concepts and directions developed into the association today.

I think specific areas of conflict between the University and JHEP are going to be in the area of housestaff - what types of assignment; who have to pay for what; the question of student assignment, elective versus compulsory programs in the various hospitals, etc.; and faculty relations. We will certainly run into conflict occassionally because of somebody who is not acceptable to the respective chairman in Gainesville. However, I think these are relatively minor problems, and with appropriate understanding can be resolved.

How does one resolve these things? First, I think one of the major obstacles to cope with is the lack of understanding - the lack of communication. The fact that we are holding this meeting today, 18 months after we started our organization, I think is a good example of productive communications. I think the faculty at JHEP should spend lots of time in the next few months, during the next year, in departmental meetings to develop a smooth departmental intra structure. This cannot just happen by goodwill or by an appointment form that is signed by somebody in Tigert Hall in Gainesville. I think this can only be done by understanding and effort.

I think the JHEP Dean's Committee has to meet very frequently because I think the co-chairmen and the chairmen of the JHEP Departments are the key to development of a mixed faculty.

if the co-chairman has no say and no real participation in the planning process the voluntary faculty will always feel that it is left behind and left out. I think the Dean's JHEP Advisory Committee can be a productive liaison group between the Jacksonville faculty and the Gainesville faculty.

I think faculty meetings like this should be held frequently. Perhaps the faculty should have an organization of its own. The JHEP faculty would thus have the mechanism to call meetings and say to the Assistant Dean and Department Chairmen, "What have you done, what have we done, where are we?" etc. I think that's very healthy for the institution to have an independent faculty organization, which rules its own and keeps them on the go. We have such an organization in Gainesville, and at the College, and I have to admit it's not always pleasant to go to their meetings because one never knows what is going to happen. However, I think it's very healthy.

We have to define it - the relationship between the voluntary and the full-time faculty. We need to more clearly define some of the educational programs, set certain goals in the program, like graduate education, continuing education and undergraduate medical education. Think about new ways to do things. I think there are many, many more opportunities today to go to new avenues than there was ten years ago. The technology of education has developed so terrifically and yet remains unutilized. There is a whole field open for a community like this to work in. How we are just as much behind in many respects as you are! And we are planning to develop our own techniques, which are particularly suitable for the main campus; but there are techniques that are more suitable for the community oriented programs.

Another place where we have to make major efforts is establishment of research program. I think it's very possible that the JHEP Program can identify with research efforts (and I don't mean exclusively in our molecular biology research, which has been predominant in the last two or three decades). I do mean research that deals with the total aspect of medical education - health care, patient care, understanding of human diseases, social or physiological, etc. I think much more research today is "acceptable research" in medical circles than it used to be some years ago. I think in the long run if you want to develop a strong academic program, you have to have a research component. I think this faculty should spend some time thinking of how it will develop research and finance it.

I think another area in which we hope a group such as yours will do more than we can in our central university location is to ask some fundamental questions regarding education and the practice of medicine. You can observe efficiently, you from your vantage point, some of the advantages and disadvantages of our present system, i.e., how we educate our students for the practice of medicine.

If the chairman gives me another five minutes, I want to explain a couple of things about our medical student program. Two years ago, that is in the fall of 1969, we started with our first class in the new program, which was based on introducing the student to the patient and the disease in phases. It should offer a great degree of flexibility in terms of student choice, student motivation and student involvement in his own planning for a career. It shows us a view of a students original motivation in medicine, to his patient and to the practice of medicine. It should add a new component in terms of experience for the student for the kind of patient care you might encounter in later life. And finally, I think it should also offer great flexibility in the speed with which a student can plan his total medical education versus a rather rigid system which we are living in now.

JHEP POLICY MANUAL

This forms the implementation of the Jacksonville division of the J. Hilli. Miller Health Center, as set forth in the document of affiliation entitled Jacksonville Hospitals Educational Program, dated August 27, 1969 and approved by the Board of Regents in October, 1969.

I. INTRODUCTION

The document of affiliation (appendix) represents the culmination of work began early in the decade of 1960 to associate the medical educational organization in Jacksonville with the College of Medicine at the University of Florida in Gainesville. The objective of the association as stated in the document was to design a plan for the development of JHEP as a division of the Health Center of the University of Florida, with increasing involvement of that division in all phases of health education. Further, in order to accomplish the stated objectives, the following activities were to be initiated:

a. formalize and strengthen the affiliation between the two agencies.

b. establish an effective faculty and administrative structure within JHEP.

c. seek a legislative mandate for this program and establish appropriate mechanisms for funding.

Since the mutual agreement to join in this association, the original document has provided the basic policy structure around which the association has functioned.

The purpose of this manual is to set forth general organizational policy and proc by which the Jacksonville division of the J. Hillis Miller Health Center relates to all agencies and is administered and funded. The original agreement (appendix) provides the source document for this manual.

II. ORGANIZATION

A. Legal Considerations

1.0 Legal definition of JHEP

JHEP is a Corporation Not for Profit organized under the Laws of Florida governing such Corporation.

2.0 Legal definition of the association with Florida State Board of Regents

JHEP as a corporate entity has a very loosely defined association with the J. Hillis Miller Health Center. By written agreement between the JHEP Board of Trustees and the Florida State Board of Regents JHEP is designated as a division of the J. Hillis Miller Health Center of the University of Florida. To the extent that JHEP operates as an independent entity not in the business of the Health Center it is an independent corporation with no master.

A. Legal Considerations (cont.)

3.0 Liability of regents for education activities of JHEP

Under the doctrine of Sovereign Immunity the Board of Regents as an agency of the State of Florida would not be liable for any educational activities of JHEP.

3.1 Liability of Board of Regents for all other activities of JHEP

By reason of the doctrine of Sovereign Immunity the Board of Regents would also be immune from liability for any other activities of JHEP, with certain exceptions as shown below in 3.2.

3.2 Liability of Board of Regents for malpractice of the faculty, resident and students

Under Section 240.191, Florida Statutes, the Board of Regents is authorized to purchase liability insurance for any institution under its management, control, or supervision, and any sovereign immunity is waived to the extent of the liability insurance coverage. The Board of Regents has purchased such liability insurance through the office of Vice President for Health Affairs at the J. Hillis Miller Health Center to cover its liability which might arise from the malpractice of the faculty, residents and students who are acting as servants and employees of the Health Center.

A. Legal Considerations (cont.)

3.2.1 Liability of Board of Regents for University of Florida students rotating to JHEP

See 3.2 above. Liability of the Board of Regents (to the extent of insurance coverage afforded) could be created by any student rotating to JHEPwhile he was acting as an agent, servant or employee of the J. Hillis Miller Health Center.

3.2.2 Liability of Board of Regents for JHEP housestaff rotating to University of Florida

See 3.2.1 above. The same proposition would apply.

3.2.3 Liability of Board of Regents for JHEP housestaff working in Jacksonville

See 3.2.1 above. The same proposition would apply.

B. Organizational Definition of JHEP

JHEP is a consortium primarily composed of hospitals in Jacksonville. In addition, there are other members who are organizations interested in furthering the goals which find expression in JHEP: coordination and cooperation of resources to more

B. Organizational Definition of JHEP (cont.)

efficiently manage professional health education in Jacksonville members of the corsortium make up a Board of Trustees which carries the responsibility of overall policy making for JHEP. There is a staff and library headed by the Executive Director.

1.0 JHEP relationship to member hospitals

The corporate JHEP related to hospitals and other members through the Board of Trustees. The Board utilizes the Executive, Finance and other committees to carry out its policies through the staff. Hospitals and other Board members have the sole responsibility for maintenance or dissolution of JHEP as a corporation.

2.0 JHEP relationship to the College of Medicine

JHEP relates to the College of Medicine in a fashion analogous to the VA hospital in Gainesville. Though a separate legal entity, certain of its functions have been delegated by the Board to the Dean of the College of Medicine, e.g. responsibility for all educational programs. JHEP relates to the College of Medicine through the Assistant Dean, who should also be the Executive Director.

B. Organizational Definition of JHEP (cont.)

3.0 JHEP relationship to other colleges and schools of the J. Hillis Miller Health Center

JHEP relates to the J. Hillis Miller Health Center as an off campus educational extention service or department. Organizationally, JHEP is analogous to the Agricultural Extension.

4.0 JHEP relationship to the Board of Regents

JHEP as a corporation has no logal relationship as servant of the Board of Regents. The JHEP Board of Trustees has delagated to the College of Medicine responsibility for educational program in JHEP, thus the Board of Regents may exercise such prerogatives from time to time through the College of Medicine, as it desires, to carry out its education objectives in health education for the State.

C. Faculty Structure

One of the stated objectives of the College of Medicine at the University of Florida is to collaborate with medical communities in developing joint educational programs. The purpose of this joint program is to develop and make available local resources for all phases of medical education.

C. Faculty Structure (cont.)

Since the major resource for this program is the quality of instructional staff, JHEP and the University of Florida have entered into an agreement aimed at the development of a medical faculty.

As closely as practicable, the organization of the faculty in Jacksonville will parallel the one in Gainesville. It's educational and administrative relationships will assume a posture of replication of organzation but not necessarily program content.

1.0 Assistant Dean

As provided in the Document of Affiliation, the Director of JHEP is titled the Assistant Dean of the College of Medicine. He should be a full employee of the College of Medicine. The Assistant Dean has overall responsibility for all medical educational programs in Jacksonville which are associated with the College of Medicine. He embodies the College in Jacksonville.

1.1 Relationship to Dean, College of Medicine

The Assistant Dean for JHEP is accountable to the Dean of the College of Medicine for all programs in medical education that are associated with the College of Medicine.

C. Faculty Structure (cont.)

The Assistant Dean for JHEP will address all communications to administrative officials of the University of Florida to the Dean of the College of Medicine for approval and transmittal.

The Dean may hire, dismiss, promote, and set the salary and fringe benefits of the Assistant Dean. However, the Dean may not exercise these perogatives with the position of Executive Director of JHEP.

All authorities vested in the Dean by this manual may be delegated to the Assistant Dean.

1.2 Relationship to the J. Hillis Miller Health Center and the Vice President for Health Affairs

The JHEP expansion into health related areas will come about only after a productive and educationally acceptable structure has been constructed for medicine. Because of this, the Assistant Dean will relate to the Health Center and higher agencies through the Dean of the College of Medicine. Relations with similar level faculty at the Health Center may be maintained, but with the knowledge of the Dean of the College of Medicine.

Jacksonville programs in the health related fields are desirable. At sometime in the future, when JHEP provides health related analogues to the Assistant Dean, the Assistant Dean may act as a "Assistant Vice

President of Jacksonville programs" and will relate directly to respective deans. At that time the Assistant Vice President will relate directly to the Vice President for Health Affairs and carry dual titles and responsibilities.

1.3 Relationship to the JHEP Board and the medical community in Jacksonville

The Assistant Dean should be the Executive Director of JHEP. As such, the Executive Director will relate to the JHEP Board of Trustees in a fashion analogous to employee. He has a responsibility to carry out the policies set by the Board and represent it in dealing with all corporately external agencies, including the University of Florida. The Board may dismiss the Executive Director, set his salary or fringe benefits (with concurrence of the Dean) and determine requirements for the position.

It is possible that the Executive Director may not be the Assistant Dean for Jacksonville. In such case, the Executive Director will relate to the Board and the Assistant Dean will relate directly to the Dean.

The position of Assistant Dean is a University title and as such carries no legal authority with the Board, thus, the Board may not dismiss, hire, or set salary, etc. of the Assistant Dean.

C. Faculty Structure (cont.)

2.0 Full-Time Faculty

In order to enhance the medical education in Jacksonville, the University Hospital of Jacksonville (formerly Duval Medical Center) began securing full-time clinicians of academic stature in 1968. It was natural that these highly qualified physicians direct the JHEP departments, and such has been the system. Some of these individuals carry the title of Chief of Service at a hospital as well as Chairman of the respective JHEP department. After consumation of the association of JHEP and the University of Florida, these individuals were given academic appointments within the College of Medicine.

JHEP Department Chairmen have the responsibility and authority for the conduct of graduate programs under their aegis. This refers to selection of housestaff, assignments, program planning and operations. They are responsible for the quality of the program and for its evaluation. In carrying out this role, they will obtain the counsel and support of their Department Chairmen at the College of Medicine.

It is also the responsibility of JHEP Department Chairmen to see that policies and educational content, as defined by the College of Medicine, are fulfilled for students assigned to their departments. The overall responsibility for the student's activities in a department resides with the Chairman at the College of Medicine.

C. Faculty Structure (cont.)

2.1 Relationship to the Dean and Assistant Dean

Since the Assistant Dean is delegated overall responsibility for Jacksonville programs by the Dean, he will exercise authority and direction of the Jacksonville faculty.

JHEP Department Chairman will communicate with the Dean of the College of Medicine through the Assistant Dean for JHEP, with copy to the Department Chairman at the College of Medicine.

Copies of definitive communications between department chairmen at the College of Medicine and at JHEP which involve matters of policy, personnel, financing and scheduling will be sent to the Dean of the College of Medicine and the Assistant Dean for JHEP.

2.2 Relationship to the faculty at the College of Medicine

The Jacksonville full-time faculty will relate to the faculty at the College on a peer basis, analogous to faculty in Gainesville. College of Medicine Department Chairmen have delegated to them responsibility for the quality of medical education in Jacksonville and as such, exercise program authority.

The JHEP Department Chairman is held accountable to the appropriate Department Chairman at the College of Medicine for the program for programs involving medical students.

2.3 Relationship to the JHEP Board and medical community

The full-time faculty who are JHEP Department Chairmen will relate to the Jacksonville medical community through each Department Executive Committee which is a standing JHEP committee. As specified in the Document of Affiliation this committee is composed of the applicable hospital chiefs and other as may be chosen by the Chairmen. There will be an Associate Chairman as provided for in the Document. For activities relating to selection of housestaff, assignments, program planning and operations and quality control, the JHEP Department Chairmen are accountable to the Assistant Dean for JHEP. The full-time chairmen, as faculty, will carry primary responsibility for continuing education of the medical community. This faculty will relate to the JHEP Board through the Assistant Dean. The Board will have hiring authority of Department Chairmen with concurrence of the College of Medicine, but not full-time faculty, chiefs of service or academic appointments.

C. Faculty Structure (cont.)

3.0 Volunteer Faculty

The establishment of a volunteer faculty, composed of practicing Jacksonville M.D.'s is an intergral mission to that of improving medical education in Jacksonville. The volunteer faculty will act as a clinical teaching resources for undergraduate, graduate and post graduate medical education programs of the College of Medicine.

3.1 Relationship to the Assistant Dean in Jacksonville

The Assistant Dean will be the head of the volunteer faculty, thus all administrative links between the faculty and the College of Medicine, the JHEP Board, hospitals and JHEP Department Chairmen, etc. is through him. The Assistant Dean may delegate to the respective JHEP Department Chairmen administrative responsibility for the departments. The volunteer faculty will relate to the Assistant Dean through his Dean's Committee and the Faculty Senate.

3.2 Relationship to the full-time faculty in Jacksonville

The full-time faculty in Jacksonville represent the major financial/ educational effort of JHEP and thus are a resource to the volunteer faculty. The volunteer faculty will relate to the full-time members who are Department Chairmen through the respective department executive committees (section C 2.3) and the Faculty Senate.

C. Faculty Senate (cont.)

3.3 Relationship to the faculty and organization at the J. Hillis Miller Health Center

The Jacksonville volunteer faculty will relate to the Gainesville structure in a manner identical to that of the clinical faculty.

4.0 Jacksonville Faculty Organization

There shall be a JHEP faculty organization, called the Faculty Council, composed of all Jacksonville physicians having University of Florida appointments to serve as a forum for JHEP/University of Florida faculty members. By means of this organization, the faculty is involved in and can aid in decisions as to academic programs, appointments system, relationship with College of Medicine and governance of JHEP.

Faculty Council - composed of entire faculty

Faculty Senate - twenty persons

Ten to be chosen by specialty groups, i.e. one from each of specialties involved in educational programs.

Ten at large, chosen by entire Council.

C. Faculty Senate (cont.)

Terms — Group "a" for two years

Group "b" one year at first thereafter each for a two year term, giving a staggered committee.

Officers — Chairman and Vice-Chairman

Election - two Nominating Committees, each to bring in slate, nominating from floor by slate

Terms - Chairman, one year; Vice-Chairman is Chairman - elect

Functions — To operate through committees appointed by Senate Chairman.

Committee Chairman to serve one year and Vice-Chairman is Chairman - elect.

Committee Chairmen are from Senate. Members may be from Senate or entire Council.

Committees to include such as grievance, bylaws, finance, public relations, community service, program development, etc.

Relationship — In order to obtain liaison with appropriate organizations, the Chairman of the Council will maintain communications with the Assistant Dean.

C. Faculty Senate (cont.)

Authority line of the Senate Chairman is direct to the Assistant Dean.

III. PERSONNEL

A. Faculty (medical and other)

To insure the productive development of the Jacksonville division of the J. Hillis Miller Health Center, a faculty encompassing the spectrum of health and related sciences will be established. Several modalities are available for a faculty appointment. The following outlines, policies and procedures for appointment of physicians jointly to the College of Medicine and to JHEP.

1.0 Types of Appointments

There will be three types of appointments: full-time tenure accruing; full-time nontenure accruing; part-time (adjunct). With the concurrance of the Assistant Dean and the Dean, a full-time member will have the option of choosing which type of full-time appointment he desires.

All appointees, irrespective of classification, are considered annually for reappointment.

A. Faculty (medical and other) (cont.)

1.1 Full-time tenure accruing (Full academic with tenure accrual)

For this, at least 50% of the salary will be provided through the University of Florida. Such appointments carry no specific institutional designation, e.g., Associate Professor of Pediatrics (JHEP).

All recommendations for appointments will be initiated after sufficient consultation and agreement between the respective chairmen at JHEP and the College, and the Assistant Dean for JHEP.

New appointments shall be initiated by the Department Chairman and shall include the following items:

Five (5) copies of Form #250

Two (2) copies of Form #270 (Biographical Sketch), with signatures

Two (2) copies of Curriculum Vitae

Two (2) copies of Bibliography

Two (2) copies of three letters of recommendation by persons outside the Health Center and JHEP for appointments to the level of Assistant Professor, Associate Professor or Professor.

A. Faculty (medical and other) (cont.)

Two (2) copies of a statement of the duties of the appointee, signed by the Chairman of the JHEP Department. This statement will be signed by the Assistant Dean for JHEP.

If the appointee is to have clinical responsibilities at the J. Hillis Miller Health Center, this is designated by typing Practice Privileges under "Remarks" on Form #250.

Completion of Checklist which will also provide the necessary information in regard to licensure.

These materials are to be approved by the JHEP Department Chairman and the Assistant Dean for JHEP, who shall send them to the Department Chairman at the College of Medicine with a letter of transmittal. After action by the Department Chairman of the College of Medicine, he shall forward the appointment to the Dean of the College of Medicine for his action. These appointments will be signed by the Assistant Dean for JHEP, the respective Department Chairman for JHEP and the College of Medicine and the Dean of the College of Medicine before forwarding to the Vice President for Health Affairs for recommendation to the President of the University.

For reappointments form #250 is to be completed annually by the individual concerned and routed through the same channels as above.

A. Faculty (medical and other) (cont.)

1.2 Full-time nontenure accruing (Full academic without tenure accrual - institutional type)

No more than 50% of the salary may come through the University of Florida. Such appointments carry specific designation, according to affiliate institutions and the institutions furnishing funds, for the physician, e.g., Assistant Professor of Medicine (JHEP/University Hospital); Professor of Surgery (JHEP/Baptist Hospital). In instances where several hospitals support one faculty member, there will be the designation of JHEP, e.g., Associate Professor of OB-GYN (JHEP). The mechanisms for appointment are as in 1.1 above.

1.3 Volunteer (adjunct)

For the volunteer faculty, primarily practicing physicians. No cognizance is taken of income, and all such appointments carry institutional designation, (JHEP), e.g., Clinical Associate Professor of Pediatrics (JHEP).

All recommendations for appointments will be initiated after sufficient consultation and agreement between the respective chairman at JHEP and the College, and the Assistant Dean for JHEP.

A. Faculty (medical and other) (cont.)

The JHEP Department Chairman shall prepare the following materials when recommending new appointments:

Five (5) copies of Form #250

Two (2) copies of Form #270 (Biographical Sketch), with signatures

Two (2) copies of Curriculum Vitae

Two (2) copies of Bibliography

Two (2) copies of letter stating duties and qualifications of the appointee, signed by the Chairman of the JHEP Department

These materials are to be approved by the JHEP Department Chairman and the Assistant Dean for JHEP, who shall send them to the Department Chairman at the College of Medicine with a letter of transmittal.

After action by the Department Chairman at the College of Medicine, he shall forward the appointment to the Dean of the College of Medicine for action. These appointments will be signed by the Assistant Dean for JHEP, the respective Department Chairman of JHEP and of the College of Medicine. The Dean of the College of Medicine will forward materials to the Vice President for Health Affairs for recommendations to the President of the University.

A. Faculty (medical and other) (cont.)

Notification of appointment will be in the form of a letter signed by the Dean of the College of Medicine and by the Assistant Dean for JHEP.

For reappointments a memorandum is required from the JHEP Department Chairman and routed through the same channels as in 1.1 above.

2.0 Salary Considerations

Remuneration for full-time faculty is governed by two policies. Full-time, tenure accruing appointments are full-time members of the faculty and as employees of the University of Florida who happen to be stationed in Jacksonville. Full-time, nontenure accruing appointments suggest that the individual is an employee of a separate institution but meets the qualifications for academic appointments. Because of these distinctions, more control is exercised by the Dean over salaries of tenure accruing than nontenure accruing. Thus, the Dean will set the salary of the Assistant Dean and other tenure accruing appointments. Institutions providing support will set the salaries of faculty having nontenure appointments, with the concurrence of the Dean. In the case of a nontenure member whose salary is funded from several institutions through JHEP, the JHEP Board of Trustees will set the salary, with the concurrence of the Dean. This concurrence may be delegated by the Dean to the Assistant Dean.

A. Faculty (medical and other) (cont.)

Volunteer clinical faculty have been defined to be predominantly private practitioners. As such, the Dean has no authority regarding salary matters for this type of appointment. In the case of volunteer faculty who are employees of institutions, that institution will set the salary without action by the Dean.

3.0 Management of Private Practice Fees for Full-Time Faculty

Full-time members with tenure accruing appointments will adhere to the policy normally governing private practice fees of faculty at the College of Medicine (see Board of Regents Academic Enrichment Fund policy).

Full-time members with nontenure accruing appointments will follow similar procedures by establishing an analogue to the Academic Enrichment Fund at the College of Medicine. Three essentials will be required of the analogue:

3.1 All professional fees accruing to faculty from payments resulting from clinical practice will be deposited in a fund.

3.2 These funds may be utilized for salary supplements, travel, educational expenses and do not accrue to benefit of participants. No claim on funds may be exercised by the participants within while a faculty member or after termination. A responsible administrative official other than the faculty participants will collect, disburse and manage the fund.

3.3 An annual certified audit of the fund will be accomplished, with copies provided to the Assistant Dean, Dean, Vice President for Health Affairs and the Board of Regents.

4.0 Private Practice of Voluntary Faculty

No authority is vested in the Dean, Assistant Dean, or other Board of Regents official or JHEP regarding private practice fees of the volunteer faculty.

5.0 Promotions

Since all appointments come up for renewal annually, promotions and deletions are also considered at this time.

5.1 Full-time faculty

Promotions will be recommended by the JHEP Department Chairman to the Department Chairman at the College of Medicine. A letter of endorsement will be forwarded by the Assistant Dean for JHEP with these materials. In concert, the Department Chairmen will present this to the College of Medicine Promotions Committee.

A member of the JHEP faculty will be appointed to the Promotions Committee of the College of Medicine by the Dean after consultation with the Assistant Dean for JHEP.

A. Faculty (medical and other) (cont.)

The Assistant Dean for JHEP will represent JHEP at the Promotions Meeting of the Executive Committee of the College of Medicine.

All such recommendations will then be processed through regular University channels, i.e., the University Personnel Board, and the President of the University.

Promotions of full-time who are also JHEP Department Chairmen will be conducted similarly with recommendations being instituted by the Department Chairmen at the College of Medicine.

Deletions will be conducted similarly.

5.2 Volunteer clinical faculty

There will be a Promotions Committee for JHEP, composed of members from the full-time and clinical faculty. This committee will act as the Jacksonville analogue for Jacksonville volunteer faculty. The JHEP Promotions Committee will have three representitives from the JHEP faculty organizations (see C.4.0), elected by the Council, who are volunteer and three who are full-time. All must possess the faculty rank of Full Professor. The Assistant Dean is Chairman of this Committee. Each member will serve a one year term any may re re-elected.

A. Faculty (medical and other) (cont.)

5.2 Volunteer clinical faculty (cont.)

Each committee member will be furnished a copy of Curriculum Vitae, a list of teaching assignments, action of the Departmental Executive Committee and the letter of recommendation from the JHEP Department Chairman.

At meetings of the Promotions Committee, the JHEP Department Chairman will present materials on his candidates. Each Committee Member will ballot (in secret) indicating "yes" or "no". The results of the committee action, plus any comments from it will be forwarded to the Dean of the College of Medicine through the Chairman of the appropriate department at the College for action.

Promotions will be considered by the JHEP Department Chairman and his Advisory Committee. The letter of endorsement by the JHEP Department Chairman should state action of his Advisory Committee. All promotions to the level of Clinical Associate Professor and Clinical Professor will be presented to the JHEP Promotions Committee.

Form #250 will be completed and forwarded with letter of endorsement from the JHEP Department Chairman and the Assistant Dean for JHEP and routed through the same channels as in Paragraph 1.1 above. Action of the JHEP Promotions Committee will be included where applicable.

A. Faculty (medical and other) (cont.)

As in 4.1, such recommendations will then be processed through normal university channels.

6.0 Other Faculty Personnel Matters - Fringe Benefits, etc.

As with salary and private practice fees, fringe benefits (leave, retirement fund, etc.) management is determined by the type of faculty appointments.

B. Career Services and Administrative Personnel

Individuals employed through JHEP but fully paid by the State will come under applicable University of Florida policies. Individuals in line positions may be dismissed or given raises through normal University of Florida channels. Individuals partially or totally paid by JHEP will come under JHEP personnel policies for that portion of their time.

IV. EDUCATIONAL PROGRAMS

A. Undergraduate

The development of programs for students in Jacksonville will follow these guidelines.

Departmental Programs in Phase B or C. The JHEP Department Chairman will prepare the descriptive material outlining objectives and content. He will forward this to the Department Chairman at the College of Medicine with a copy to the Assistant Dean for JHEP. The Department Chairman at the College of Medicine will forward the final protocol to the Chairman of the appropriate Curriculum Committee. Notification of action will follow the reverse chain of communication.

Interdepartmental Programs in Phase B or C. If more than one department is involved in a proposed program, the JHEP Department Chairmen will plan the program with appropriate Department Chairmen at the College of Medicine. The final proposal will be forwarded to the EPPC and to the appropriate Curriculum Committee by the Assistant Dean for JHEP, with copies to the involved Department Chairmen. Notification of action will follow the same pattern.

1.0 Mechanism for Student Rotation in Jacksonville

Arrangements for special electives as Part of Phase B or C assignments will be accomplished between Department Chairmen at the College of Medicine and JHEP, with approval of the Phase B or C Committee and the Assistant Dean for JHEP.

Students seek approval for listed Phase C programs in JHEP from their faculty advisor. The final proposed program is presented to the class advisor who transmits it to the Phase C Committee.

A. Undergraduate (cont.)

1.1 Student Rotations in Jacksonville in Phases B and C

Increasing numbers of students will be taking clinical rotations in Jacksonville (principally in Phase C, but also at times in Phase B). In order to coordinate this program, assure proper credit and evaluation of performance, and also to make certain that students are informed about housing and per diem arrangements, the following mechanism should be utilized:

1.1.1 Phase C: Following approval of the Phase C selections, the Phase C Chairman will inform the Office of the Dean (Associate Dean) of students who have selected Jacksonville rotations. This information will be transmitted to the Assistant Dean for JHEP who in turn will inform the respective Jacksonville and Gainesville Department Chairmen.

At the beginning of a rotation in Jacksonville, each student should report to the Assistant Dean for JHEP to complete housing and per diem arrangements where applicable (and when available).

The Assistant Dean for JHEP will be responsible for forwarding evaluation of student performance to the Office of the Dean in Gainesville.

A. Undergraduate (cont.)

1.1.2 Phase B: Department Chairmen (Gainesville) will inform the Phase B chairman of students who will be assigned to Jacksonville. This list will be transmitted to the Office of the Dean and the same procedure followed as above.

Changes in Assignment: For a student who either drops a prescheduled rotation in JHEP or who plans to take a previously unscheduled rotation to JHEP, the class advisor will send to the Assistant Dean for JHEP, and to the appropriate Department Chairman at the College of Medicine and at JHEP, a copy of the signed form permitting this change.

All students coming to JHEP will report to the Assistant Dean's office which will serve as official contact point for students while in Jacksonville.

2.0 Housing and Related Subsistance Items

Every effort will be expended to provide rotating students a per diem, and a suitable lodging at very low or no cost. No provisions will be made for families of students.

3.0 Program Content

All programs involving University of Florida undergraduate medical students in Jacksonville will be surveyed and approved by the applicable faculty in Gainesville prior to initiation by JHEP. Content will be monitored by the Assistant Dean for JHEP.

At the conclusion of each student's assignment, the JHEP Department Chairman will forward to the Department Chairman in Gainesville appropriate evaluation forms. A copy of this will be sent to the Assistant Dean for JHEP. The Chairman of the department at the College of Medicine will forward this to the Dean of the College of Medicine.

Student evaluation of the JHEP program will be sought by the Phase B or C Committee. Copies of this evaluation will be made available to the JHEP Dean's Committee.

4.0 Financing

The Dean of the College of Medicine, when possible, will help to defray the additional living expenses for students assigned to JHEP.

All remuneration paid students rotating to Jacksonville will be funded through JHEP. JHEP will use all available agencies for sources of funds.

B. Graduate

1.0 JHEP Housestaff in Jacksonville

B. Graduate (cont.)

1.1 Administration

JHEP will administer all facets of the Jacksonville residency programs which are JHEP residencies.

1.2 Program content will be the responsibility of the respective Department Chairmen in Jacksonville.

1.3 Financing

Financing of the residency facet of JHEP is through hospital reimbursement of housestaff salaries. At such time in the future as housestaff are employees of JHEP, financing will be conducted similarly.

2.0 Interinstitution Rotations of Housestaff

Plans for rotation of residents between JHEP and the College of Medicine will be formulated by respective Department Chairmen in the two institutions. Following this, the Dean at the College of Medicine and the Assistant Dean for JHEP will be notified in writing of the impending rotation. This should be accomplished at least two months before the rotation is scheduled to permit the administrative head of the respective institutions to negotiate financial matters (salary, per diem, etc.). A variety of arrangements can be developed for handling the financial aspects of rotating residents. The Assistant Dean for JHEP will act on the recommendations. All financial matters will be handled through JHEP and that organization will be the disbursing agent. The JHEP Financial Policies will be followed except when they conflict with this manual, in which casethis manual will supersede.

The JHEP Financial Policy allows the following: Housestaff rotations to the College of Medicine are determined by the respective JHEP Department Chairmen. Rotations will be given on the basis of educational benefit. Determination of which institution pays - JHEP or the College of Medicine - will be negotiated between the appropriate departments.

2.1 Salaries will be prorated among hospitals having residents of the given specialty.

2.2 Fees will be prorated in accordance with a pro rata assessment of Jacksonville hospitals.

2.3 Living expenses and other miscellaneous items will be the responsibility of the resident, who will be paid a perdiem of $5.00 while on rotation to Gainesville. The monthly total of the $5.00 per diem will be prorated as in paragraph (2) among the hospitals.

B. Graduate (cont.)

3.0 Other JHEP Housestaff Rotations and Travel

Travel to conferences will be awarded only on the premise of educational benefit to housestaff, past the first year of post M.D. training, whose effort commend such and upon recommendation of the respective JHEP Chairman.

Conferences are ordinarily restricted to the Continental United States and a radius of air travel amounting to $150.00 round trip tourist fare. Travel outside these limits requires special approval of the Assistant Dean.

JHEP will pay expenses for the resident's travel from the Resident Travel Fund established each July 1 in accordance with a pro rata assessment of hospitals, and other sources when available. Each department or division will have a pro rata share of the travel fund for use by the Chairman in awarding travel.

Expenses incurred by the resident will be reimbursed up to a maximum of $30.00 per day. Air fare, transportation, and registration fees are in addition to this $30.00 per diem. Chairmen may set a limit for a particular trip less than the above; however, expenses will not be allowed over this limit.

C. Continuing Education

For purposes of this document, Continuing Education programs are defined as special guest lectures, seminars, courses and conferences. This includes programs generated by hospitals, specialty societies or individuals. For all such programs the Assistant Dean for JHEP will be notified at the time planning begins.

1.0 Joint Programs

The Assistant Dean has responsibility for all jointly sponsored Continuing Education programs in Jacksonville. The Assistant Dean will:

Aid in conference details, aid in publicity, in planning and establishment of objectives and in financing;

Notify the Assistant Dean for Continuing Education in order to obtain co-sponsorship;

Arrange for sponsorship and credits from appropriate organizations;

Make available staff services;

Aid in evaluation.

In addition, the Assistant Dean for JHEP may assume the initiative in planning programs with the advice of appropriate committees.

C. Continuing Education (cont.)

2.0 Program Content

The Assistant Dean will assure that jointly sponsored Continuing Education exercises conducted in Jacksonville are of an educational merit to warrent University of Florida association.

Those programs in Jacksonville that are not handled as in C.l above cannot be said to be either JHEP or University of Florida sponsored Continuing Education programs.

3.0 Financing

Every effort will be made to insure that all educational conferences directly sponsored by JHEP are self paying. Sources of funds such as State, Federal and private grants, and registration fees will be used to defray conference expenses.

V. FISCAL CONSIDERATIONS

A. General Financial Structure of JHEP

1.0 Dues

All JHEP members pay institutional dues. Dues are prorated to Category I members as follows: These dues will be prorated to these eight institutions by the following formula: 50% (35,000) will be divided equally among all hospitals, for a total of $4,375 per hospital. The remaining 50% (35,000) will be prorated on the basis of total JHEP housestaff salaries paid. Thus, a hospital with no JHEP housestaff will pay the base of $4,375 annually. This figure is defined as Base Dues and forms the basis for dues of all category members. A hospital who pays 15% of JHEP housestaff salaries will be prorated an additional 15% of 35,000 ($5,250), for total dues of $9,625 ($4,375 + 5,250). Other category members will pay a prorata of Category I dues as stated in the JHEP Bylaws.

2.0 Grants (federal and other)

JHEP may seek, receive, and administer grants from any agency independant of the University of Florida. Overhead (indirect costs) will be computed at the rate approved for JHEP. National Institutes of Health grants will be credited to the University of Florida General Research number in order that JHEP faculty may participate in the University of Florida General Research Support Grant supplied by the National Institutes of Heatlh.

3.0 State Support

JHEP will seek increased State funding of its operations in order to provide resources for growth and not to depend solely on member support.

A. General Financial Structure of JHEP (cont.)

4.0 Budget

The budget of JHEP will be the responsibility of the Assistant Dean, who will seek advice and consent of the Finance Committee before submission to the Board of Trustees for action. Copies of the budget will be provided to the Dean of the College of Medicine and Vice President for Health Affairs.

B. Administration of State Funds Appropriated for JHEP

1.0 Budget

The Assistant Dean will prepare a budget for use of State funds appropriated to JHEP through the Health Center. This budget will be presented to the Dean of the College of Medicine for transmittal to the Vice President for Health Affairs. This budget will be administered by the Assistant Dean for JHEP.

2.0 Uses

State funds appropriated to JHEP will be utilized to further the University of Florida objectives of strengthening professional health education in Jacksonville. Standard purchasing procedures will be utilized. In aiding this objective, the Dean of the College of Medicine or any agency within the University of Florida will not attach an indirect cost to these funds.

B. Administration of State Funds Appropriated for JHEP (cont.)

3.0 Accountability

The Assistant Dean is responsible for the administration of State funds appropriated to JHEP.

C. Administration of Federal and Other Grants to JHEP

The Assistant Director of JHEP will be responsible for the administration of all Federal and other grants given to JHEP, including negotiation for indirect costs, etc., independent of the University of Florida.

D. Budget

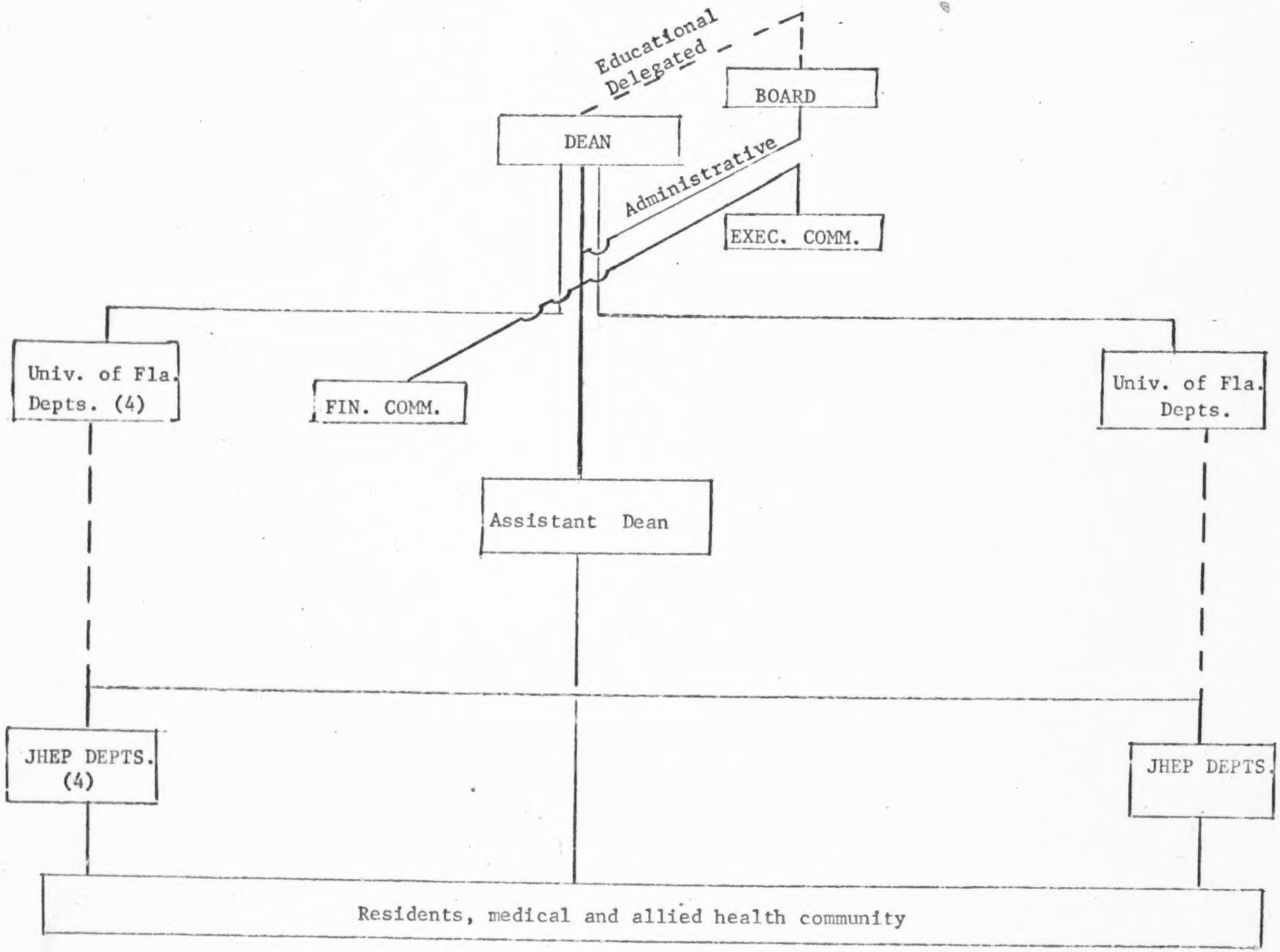
The consolidated JHEP budget will be submitted to the Dean of the College of Medicine and the Board of Trustees for final approval.

E. Comptrol

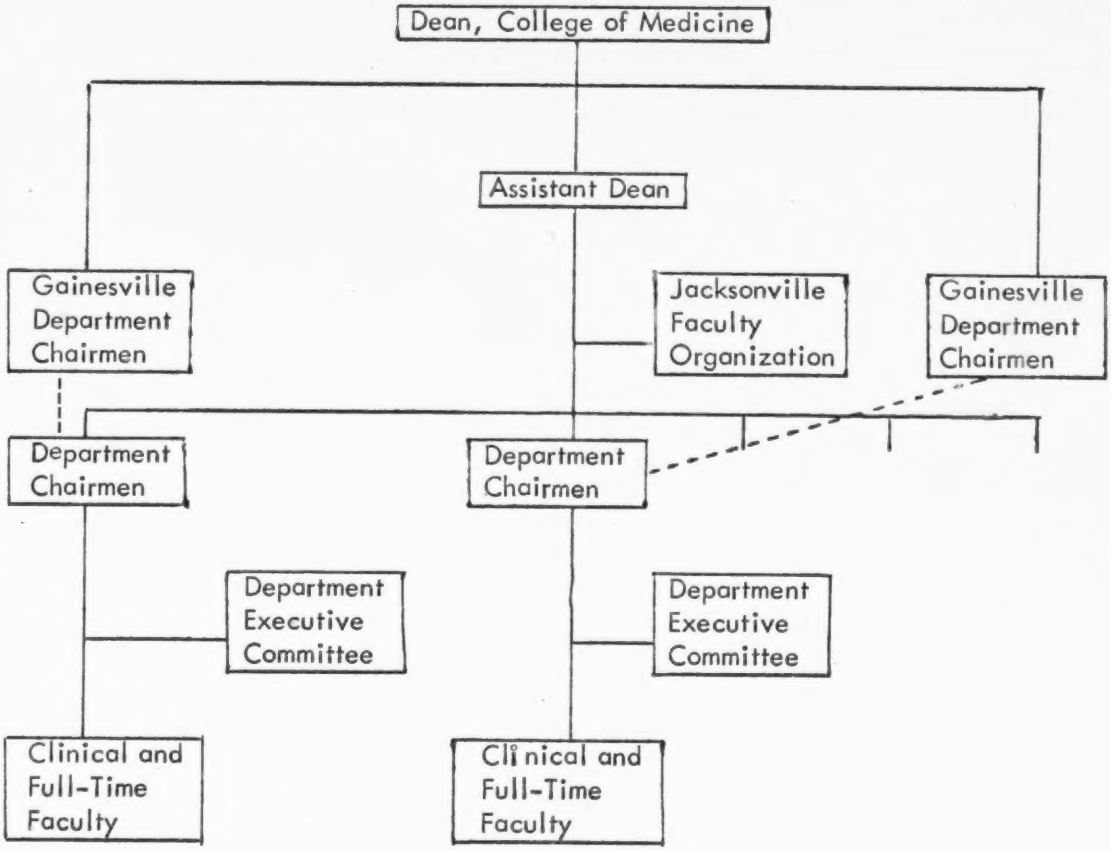
Annually JHEP will have a certified audit, copies of which will be distributed to the Board, Dean of the College of Medicine and the Vice President for Health Affairs.

VI. APPENDIX - DOCUMENT OF AFFILIATION

VII. ORGANIZATIONAL CHART


Educational
Delegated
BOARD
DEAN
Administrative
EXEC. COMM.
Univ. of Fla. Depts. (4)
FIN. COMM.
Univ. of Fla. Depts.
Assistant Dean
JHEP DEPTS. (4)
JHEP DEPTS.
Residents, medical and allied health community

ACADEMIC RELATIONS CHART


Dean, College of Medicine
Assistant Dean
Gainesville Department Chairmen
Jacksonville Faculty Organization
Gainesville Department Chairmen
Department Chairmen
Department Chairmen
Department Executive Committee
Department Executive Committee
Clinical and Full-Time Faculty
Clinical and Full-Time Faculty

SUMMARY OF PLANNING COMMITTEE RECOMMENDATIONS

SHORT RANGE OBJECTIVES

I. Set the working JHEP goal to be the educational implementor for all community medical education needs for M.D.'s, nurses and allied health professionals, utilizing all available resources, including Florida Junior College, University of North Florida, University of Florida, etc.

  a. Be a resource to University of North Florida by aiding in determination of:

    1. curriculum content
    2. demand for a particular profession
    3. requisite funding
    4. requisite faculties and facilities

  b. Establish a standing committee on nursing and allied health to act as liaison between the hospitals, University of North Florida, Florida Junior College and others.

  c. Devote adequate time and resources to continuing education by expanding staff and facilities to the minimum extent of hiring a coordinator of continuing education.

II. JHEP should maintain the excellent library, instituting aggressive management to:

  a. Reach health professionals who do not use it.

  b. Increase services to more adequately provide the source of biomedical information for the health community.

  c. Investigate desirability of moving the library to a private hospital nearer the major teaching effort.

  d. Provide stable financing.

  e. Seek to place all hospital libraries administratively under JHEP.

IMPLEMENTATION

III. JHEP should broaden its base of membership:

  a. Assure that all dues paying members have votes.

  b. Provide a type of membership for institutions and organizations which are neither hospitals nor the Medical Society.

IV. JHEP should set aside a portion of the budget each year for Public Relations and energetically carry the JHEP story to the people of Jacksonville.

V. Establish a standing committee for planning which will report periodically to the Board and recommend directions for JHEP growth.

VI. Adopt the attached amendments to the Bylaws to improve management and provide sufficient membership categories.

VII. Concern itself not with resident housing, but rather with short-term, "quasi-dormitory", for students rotating to Jacksonville.

FINANCING

VIII. Full-time chairmen should be funded as existing JHEP employees with sources as dues, grants, private practice fees, etc.

IX. Establish a JHEP Academic Enrichment Fund for participation of all full-time faculty private practice fees.

X. Establish a minimum level at which members will support JHEP. Growth beyond this level will be the responsibility of the Finance Committee using all available State, Federal and private sources.

LONG RANGE OBJECTIVES

XI. Reorganize JHEP along the lines of a health center by establishing a JHEP faculty for the community.

XII. The faculty currently being developed (as also all residents) should be a JHEP faculty with JHEP contracts, allegiance and identity.

XIII. A physically separate building from the hospitals to house JHEP and the library should be constructed.

MODELING AN AREA HEALTH EDUCATION CENTER

INTRODUCTION

The recent report of the Carnegie Commission on education in the health sciences proposed several innovations in health service and education. Among others, the Commission recommended the establishment of health education centers, which are located some distance from University Science Center, for the purposes of education and training of health professionals. Some of these centers must be located in certain metropolitan areas needing additional training facilities. Jacksonville was one of the proposed sites.

JACKSONVILLE HOSPITALS EDUCATIONAL PROGRAM (JHEP)

For the past 13 years a program, similar in concept to the Area Health Education Center, has existed in Jacksonville. This program now has 20 full-time faculty, 120 clinical faculty and 550 affiliated physicians. The effort is supported by an eight hospital consortium under the acronym JHEP. Primarily, the educational thrust is aimed at graduate medical education including internships and residency training. Currently, residencies offered include: Pediatrics, OB-GYN, Medicine, Surgery, Orthopaedic Surgery, Plastic Surgery, Urology, Opthalmology, Oral Surgery, and Family Practice. Included in enclosed materials are annual reports of JHEP, which document further its activities and interests.

New clerkships and rotations are being designed for fourth year medical students to obtain the unique clinical exposure found in Jacksonville. Also, there is a growing interest in expanding residencies and embarking upon a greater variety of health professions education such as nursing, PT, OT, PA, etc.

The JHEP program is affiliated with the University of Florida's J. Hillis Miller Health Center, however, only the Dean of the program is supported financially and accruing tenure through University of Florida. JHEP has other affiliations including the University of North Florida in Jacksonville. Also, the Cathedral Health and Rehabilitative Center and Jacksonville Blood Bank are associated with JHEP.

SCOPE AND OBJECTIVES

The JHEP program could serve as a model health education center, which might be widely replicated. Therefore, it serves as an ideal environment to study regional education programs.

While JEHP is generally viewed as being successful, little analysis has been directed to documenting its effort. We propose to develop systems models of the JHEP program to relate quantitatively to the educational service and research objectives. In particular, the institutional characteristics need to be assessed and the impact of JHEP policies and programs on resource requirements, e.g., space, personnel, facilities, require determination. The models can be utilized to objectively evaluate the training program, its curricula, and costs.

METHODS

Basically, the research aim is to develop management information system, a la Judy in Toronto, for a complex regional educational program using JHEP as the environment for investigation. The health education model would systematically and accurately determine costs, resources and demands for resources, as a function of time. JHEP administrators could communicate with the model so that the ramifications of decisions could be predicted in advance of implementation and the models could be interrogated in a "what if" fashion. For example, the impact of adding three residents in medicine on space, cost and teaching resources could be determined, and many other questions could be at least partially answered.

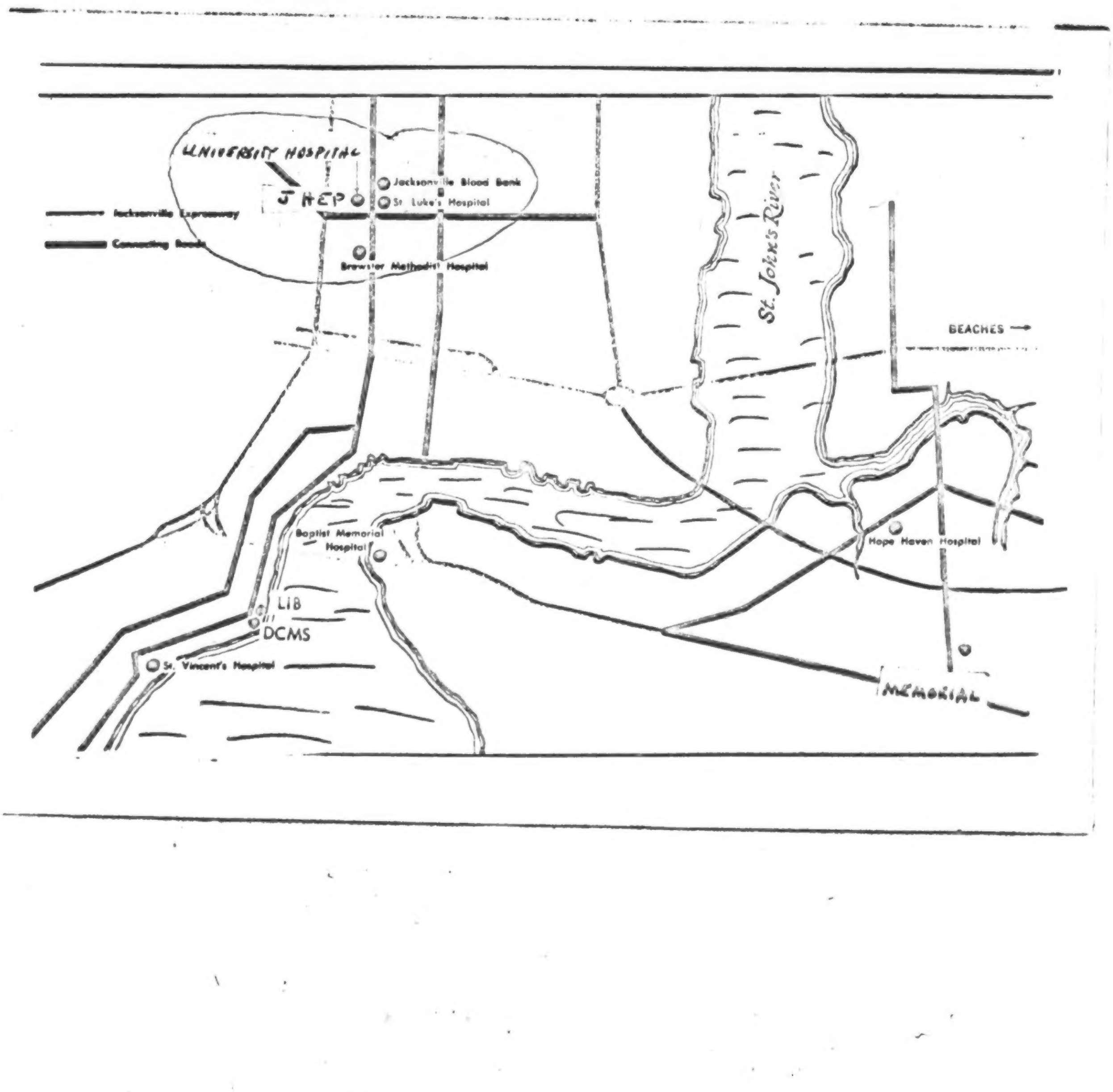
JHEP provides an excellent opportunity for the development of health education modeling. The program is currently small enough to get fairly immediate results, yet is complex in financing, policies, etc. to render the modeling non-intuitive. Because such an area health education center offers a seemingly economical method for training, there is considerable pressure for JHEP to expand its objectives, add faculty, develop new programs, etc. The evaluation of these proposals is important and could have considerable impact not only financially, but also on the health manpower supply and quality of education.

SIGNIFICANCE

Without the information or data that the proposed models offer, planning becomes traumatic. The availability of models would allow communication with the system without the emotional involvement of costly experimentation with the existing program. The capability to look at the whole system, the chance to seek the resource implications of decisions, and to even obtain partial answers to alternative actions, would be very valuable, especially in such an area health education center.

FURTHER RESEARCH

The work being proposed might be viewed as an initial, but important, effort. Having developed results from such a study, many other aspects of such centers could be examined. The information system could be expanded to include projections of demand and need for health manpower in the region. The information exchange system needs study as does JHEP's library operation.


UNIVERSITY HOSPITAL
J HEP
Jacksonville Blood Bank
St. Luke's Hospital
Jacksonville Expressway
Connecting Roads
Brewster Methodist Hospital
St. John's River
BEACHES →
Baptist Memorial Hospital
Hope Haven Hospital
LIB
DCMS
St. Vincent's Hospital
MEMORIAL